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PART 2: INTERNATIONAL NUTRITION AND HEALTH

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HEARING

BEFORE THE

INTERNATIONAL TASK FORCE

OF THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 30, 1986

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PART 2: INTERNATIONAL NUTRITION AND HEALTH

WEDNESDAY, APRIL 30, 1986

HOUSE OF REPRESENTATIVES,
INTERNATIONAL TASK FORCE,
SELECT COMMITTEE ON HUNGER,
Washington, DC.

The task force met pursuant to call at 10:11 a.m., in room 2212, Rayburn House Office Building, Hon. Tony P. Hall (chairman of the task force) presiding.

Members present: Representatives Daschle, Kostmayer, Dorgan, Evans, Gilman, and Roukema.

OPENING STATEMENT OF HON. TONY P. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. HALL. Good morning, ladies and gentlemen. My name is Tony Hall and I am thankful for the witnesses and the appearances of so many distinguished visitors. We are very pleased to have you with us today to discuss the issues of nutrition and health which, of course, affects the lives of millions of people in less developed countries.

In the past 2 years, Congress has been increasingly interested in issues of health and child survival in less developed countries. In 1984, Congress created the child survival fund at AID and supported substantially increased funding for basic health care services which was an initiative of this committee. In 1985 Congress passed House Concurrent Resolution 211, another Hunger Committee initiative. This resolution calls on the President to support the Global Immunization Program with the goal of immunizing all the world's children against six leading diseases by the year 1990.

Also in 1985 Congress approved an earmark of $8 million for vitamin A programs designed to reduce blindness, illness, and death among children in vitamin A deficient countries, including Ethiopia, Sudan, the Philippines, Indonesia, Haiti, and Bangladesh. The vitamin A initiative resulted directly from Select Committee on Hunger investigations. And this year I have been joined by 173 other Members of Congress, including most of the members of this committee, a very strong bipartisan group of members, in supporting H.R. 3894, the Universal Child Immunization Act which would increase funding for global immunization programs by $50 million and for the next 5 years including 1990.

As chairman of this task force, I am proud to support these initiatives. We are convinced that basic health care services by reducing malnutrition-related illnesses and health in developing coun-

tries can assist in furthering the human and economic development of the peoples of these nations.

I am very much aware of the pressures on the Foreign Assistance Program at this time. The need to control budget deficits is pressing, but I am also aware of the tremendous loss of life that is occurring minute by minute, day by day, year by year in this world. Immunizing all the children by the year 1990 is a goal that is doable. I think it is a question of deciding what is the highest priority. I can't think of a stronger priority in this Congress and in this world than saving approximately 4 million children from dying this year as a result of fighting these six dreaded diseases and saving another 5 million children from being impaired physically and mentally this year which could result with increased funding.

Today we have a panel of experts to tell us about the programs that will help us reach these goals. We are very thankful as a committee to hold these hearings and to support what you are doing. Before we have our first witness, Mr. Peter McPherson, the Administrator of AID, we have our ranking minority member, Marge Roukema, who is a very strong supporter of many of things that we are trying to do. Mrs. Roukema.

OPENING STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mrs. ROUKEMA. Thank you, Mr. Chairman. I will not take time to give my full opening statement, but would like to have unanimous consent to insert it into the record.

Mr. HALL. Without objection.

Mrs. ROUKEMA. I certainly want to thank Mr. McPherson for being with us today. He is a dedicated and eloquent spokesman for the administration and for the Agency for International Development.

I would simply like to make this point: as my colleague, Mr. Hall, has said, I am a strong supporter of the health programs that we will be discussing here today. I am strongly committed to the Child Immunization Program. I believe that the most important effort of this committee, the Select Committee on Hunger, is to focus on those programs that will enhance the health of the world's children.

Last year, as you already know, statistics showed that 11,000 children were dying daily in the world from the six infectious diseases targeted by our Child Immunization Program. If this number of deaths were due to a natural disaster, such as the earthquake in Mexico, there would be an immediate international relief effort undertaken, and all possible resources would be brought to bear upon the problem.

Well, we have this tragedy of children dying every day from infectious diseases, a tragedy that could be corrected by a very minimal contribution from the other nations of the world. I think that anything Mr. McPherson can do to help us move this project along would be in the interest of humanity and certainly would be consistent with what America's traditional role has been.

It seems to me there is no reason why we can't take the leadership in this area. Thank you very much.

Mr. Hall. Thank you.

[The prepared statement of Mrs. Roukema appears at the conclusion of the hearing, see p. 40.]

Mr. HALL. We now have Mr. McPherson, Mr. Peter McPherson. He is the Administrator of the Agency for International Development. Mr. McPherson, we look forward to your comments.

STATEMENT OF M. PETER McPHERSON, ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. MCPHERSON. Thank you, Mr. Chairman. This committee has certainly taken leadership on the issue of child survival. I want to state my appreciation for that fact. Child survival has become one of the Agency's highest priorities. Indeed, I believe it is a national priority; 40,000 children die each day, every day in the developing world. AID's goal is to help bring down the infant mortality rate in the developing countries to 75 per thousand by the year 2000, a 25-percent decline—still, I might point out, nearly eight times the rate in the United States. We think it is a realistic goal.

In addition, together with other agencies and donors our goal is to prevent 2 million deaths through the use of oral rehydration therapy [ORT] by 1990 and develop a sustained capacity to immunize the world's children. Many organizations must join together to meet this goal. It will require a really sustained commitment to do this job.

Incidentally, I might point out that I arrived relatively late last night from Cairo where I was reviewing AID programs there. I had an opportunity to spend some time in one of the clinics that we work with in our AID program. This clinic focuses particularly on ORT. Worldwide, there are about 5 million children a year that die from dehydration do to diarrhea. In Egypt we have had a spectacular success.

We began in a very serious way in 1983, and as of last year there were 90,000 children who had been saved by the use of ORT. In the early eighties' shortly before we began this program, 2 percent of the mothers in the country knew about ORT. A recent survey shows that today over 90 percent of the mothers know about it. In that country, access to TV is high, so that TV has done an extremely good job of communicating not only about ORT, but also teaching how to use it. It showed mothers across Egypt how to mix ORT ingredients. I am pleased with this success. We now plan to follow it with a broader Child Survival Program that will include nutrition, immunization, birth spacing, and treatment for respiratory diseases.

AID intends to provide the critical support for child survival efforts particularly in some 22 priority countries. We plan to redouble our efforts involving national leaders and other donors. Tomorrow I am traveling to New York, to continue discussions and plans for collaboration in this program with UNICEF and other child survival donors. I might point out that last fall our ICORT conference really brought together the largest donors in child survival. AID is the single largest donor in dollar terms. UNICEF and WHO

play major roles. We have—UNICEF, AID, and WHO—really agreed upon a strategy for this Child Survival Program.

Incidentally, Mr. Chairman, I want to call to the committee's attention that this strategy of AID, UNICEF, and WHO agrees on a focus on what we call our twin engines. It is not a focus just on immunizations. Immunizations can prevent the death of almost 4 million children a year, but, we figure, between 4 and 5 million die from dehydration due to diarrheal diseases.

One of the things I think you might consider is as you proceed with your legislation—we have got some questions about the funding of that within the administration, as you know—but I think we would be happy to see a twin engine approach that emphasizes both ORT and immunizations. We are talking about roughly the same number of children that could be saved by each, and I would hope we would have that broader focus.

Within the last several weeks I signed a child survival strategy for the Agency which is attached to my testimony. This, of course, is a culmination of some experience over the last couple of years and we think it is really a very good one. It includes, among other things, this concept about ORT and immunizations being twin engines.

However, we must think beyond just giving shots to kids or having ORT available for mothers to use when there is a severe case of diarrhea. We have to think about how to build a sustained delivery system. We have seen around the world immunization drives that result in a few days of mass immunization, but the difficulty is getting that to occur every few months, quarter after quarter, year after year. This is the hard part and it hasn't always worked out as well as it might, so building a child survival delivery system, creating institutions that continue to deliver those services is key.

The number of children we save in any given drive catches the headlines, and that is proper, but we should use these simple inexpensive technologies as the twin engines to build the long-term delivery system. This year we are planning to commit more than $90 million for ORT and immunizations. No other donor comes close to this level of effort, and the United States can be very proud of its leadership.

Incidentally, when I talk about that $90 million, as you can see, I am not talking about just the child survival fund, I am talking about the whole range of spigots from which we can draw. The money that we are spending in Egypt on ORT, and now a major immunization drive, is all ESF money.

A focused nutrition package and birth spacing are also critical parts of our child survival strategy. We estimate that 3 million lives could be saved each year if every infant had the best start—specifically with a 2-year interval before the next sibling is born. Some of you remember when I have given speeches on family planning, I have argued that one of the key reasons why family planning services should be broadly available is that if a mother doesn't have a child any more frequently than every 2 years, the mother is more likely to live, the child just born is more likely to live, and, really very interestingly, the child born 2 years or more ago is

more likely to live. Birth spacing is in fact also a child survival kind of effort.

Our strategy at AID places special emphasis upon 22 countries where child survival problems are especially severe and where aid can maximize our impact. These 22 countries alone account for two-thirds of all infant deaths in the world. We have selected these countries really on a very unpolitical basis. We look primarily to where the problems are, and I think that the list, which includes places such as India and Haiti, is a very impressive list indeed of where we should and will be putting our efforts.

Our child survival strategy is an Agency strategy, cutting across, as I mentioned earlier, several functional accounts. I hope as you look at how we are funding this effort that you realize that we look to the health account, the child survival fund, ESF, the Sahel and other accounts to obtain our money. In 1986, the current year, our projection is that we will put about $160 million into all types of child survival activities—$160 million. As I said a moment ago we are committing $90 million for ORT and immunization, some $50 million for other child survival activities, and roughly $21 million for related research or some $160 million for child survival activities overall.

Mr. Chairman, I think that is a figure that you will want to focus on because it is an impressive one indeed. In 1987 our levels have declined because of our overall budgetary reductions. However, by concentrating more fully on child survival priorities within our health account, we still expect to put in at least an additional $125 million, exclusive of population and Public Law 480 funds. My guess is that with the emphasis we are placing on child survival that in fact this number will rise even further as we proceed.

In our program we try to draw heavily upon the private sector, particularly many excellent private voluntary organizations, including some represented today.

We are very aware that child survival programs may be hard to sustain after the first burst of enthusiasm, but I think that this is one of the things that we need to focus on very carefully.

We have also put into our child survival efforts between $25 and $30 million a year of research—$25 million this year. About half of this total is in malaria. The malaria vaccine which we have been instrumental in developing and are now testing, is a vaccine against the worst strain of malaria. We have another vaccine against another strain, which is to be ready for testing shortly. There are at least 200 million new cases of malaria a year. It seems to me that, given the importance of malaria, there is almost no way we could spend the $15 million or so a year we spend on malaria any better. We have other research programs that I am particularly proud of. I had been quite instrumental in insisting that we spend the money for these. Last year we put several million dollars into testing the leprosy vaccine. There is no reason why in the near future we can't deal with leprosy in this world really quite completely.

We continue the ORT which is almost magical in its simplicity, but there are a number of other research follow-ons that need to be done. We are now testing or about to test a cholera vaccine—cholera, incidentally, is an extreme form of diarrhea. We have to con-

tinue, I believe, to improve the technology as well as use it. Our efforts will produce new technologies, but they will also produce, Mr. Chairman, more efficient, easier ways to use technologies we already have.

Consider vaccines for the immunizations. One of the big problems of delivering immunizations in parts of Africa, for example, is that you need heat-stable vaccines; in other words, vaccines that will continue to be effective even though the vaccines are subjected to high temperatures. Heat-stable vaccines—I won't go into what this is all about—but heat-stable vaccines aren't subject to those kinds of problems, so you don't have to have what is called a cold chain to deliver them. We are putting some effort into this. The research component of our child survival efforts, in my judgment, is a very important one.

Nutrition, obviously, is an important component of child survival. Some of this is not high technology at all but works in some of the worst ghettos in the world. Last year I took my two boys down to Haiti for a couple of days. I thought I would expose them to a world different than Chevy Chase, and as we walked through one of those just terrible ghettos, I remember asking a woman what she was seeing and feeling and how her children were doing. She pulled out a dirty crumpled old chart from deep under a pile of what seemed like rags, but it was obviously very critical to her because it was the growth chart for her child. She took him to the doctor periodically, and the doctor weighed the child and checked it thoroughly. The chart allowed a doctor and the mother to understand the kinds of things that she needed to do for her child.

Nutrition isn't always supercomplicated and highly technical. It is fairly straightforward. I know you have been personally very interested in vitamin A, and I think that is excellent. We have been happy to work with John Costello, who is here to testify shortly, and others who have helped develop the data on what vitamin A can do. We know that it can have an impact upon blindness. There is the possibility that it can have an impact beyond blindness; that maybe it does save lives per se, and make it less likely for children to get measles and other diseases.

We think that is so as a result of our Indonesian study, but we do not know that for sure. I think that it is important, Mr. Chairman, that we all recognize that the scientific community still has an open question as to whether vitamin A will save lives as contrasted to its role in preventing blindness. I strongly urge this committee not to call for large expenditures on vitamin A. Some expenditures need to be made—and I expect that next year we will continue to spend some money on vitamin A, but basically I want to see the test results before we put in massive amounts of additional money.

Therefore I ask you not to put money into vitamin A which might better be put into ORT, where you know you can save lives. Vitamin A is a sexy issue, but we know we have to get more answers. Let's put the money into getting the answers, and in a couple of years if vitamin A does what we think it might, it will be one of the most exciting public health developments. I think we need to be careful in the meantime regarding our expectations for vitamin A.

As to allocations of money, last year Congress reduced the agriculture account by $190 million and increased the health account by about the same amount. You will note that the administration, at my initiative, came back with a higher request for 1987 than we had made for 1986 in the health area. We know that the best way to save the life of a child is to feed the child. We know that we are making some important steps in time—around Africa in terms of increasing food production.

Frankly, I think that Congress still needs to look at itself as to why last year during a drought that killed hundreds of thousands and maybe many more, why they cut the agriculture account by $100 million. I appeal to this committee particularly, to consider the effects of an agriculture account that was cut $100 million last year. It is true that you can talk about the size of the security assistance, account and one can argue about the need for so much for security assistance, although you need peace in the world to make progress. But even without those arguments I think—and I am not here trying to make a big political speech about this—I believe you must be very careful not to cut agriculture, not to cut food in order to provide more money for health. Food is fundamental to health. Maybe you ought to worry about population, too. Don't cut food and population and these other accounts in order to boost something that is glamorous. In the end you must feed the children.

Now, we are putting more into this child survival effort. Congress has earmarked and set up an account, and I have responded by asking for child survival money separately. But basically I don't see that a child survival account is as important as my looking to all the spigots at my disposal within the various accounts and seeing how much child survival money I can get. That's why our child survival numbers have gone up so much.

We spent $26 million of ESF in Egypt in the last couple of years for ORT, and we are about ready to commit another $73 million out of ESF in Egypt for an overall child survival package. That is where the real numbers will come from. It is not just the child survival account per se, so what I ask, and I ask this committee with its particular mandate, is to please help me to not have the agriculture account reduced to benefit other things that are important and necessary. Overall balance is what we need to maintain.

Mr. Chairman, it is good to be here today. I do appreciate the leadership that this committee has given on a number of areas, and you can be assured of my personal commitment and the administration's commitment to the child survival effort.

As I close you might be intrigued to know that I took a series of pictures involving ORT in Egypt. A child came in at 9 o'clock in the morning, clearly hours from death. He is listless. Then with a series of spoon feedings of ORT he becomes alert and by 1 or 1:30 is sucking the mother's breast. I took those pictures and showed them to Secretary Shultz the other day, who was particularly impressed. I also told him about the worldwide immunization efforts and what we were doing. Secretary Shultz has commented about this to me a half a dozen times since. He in turn took the series of photographs to show the President when he went over there a couple of days later. The President was clearly impressed with what we are doing.

I think what you have is an administration that sees this as a very important effort, and we are pleased to have the kind of close working relationship with Congress for implementing the effort. Thank you.

RESPONSES TO QUESTIONS FOR M. PETER MCPHERSON

QUESTIONS SUBMITTED BY HON. TONY P. HALL

Question. The Child Survival Fund was designed to fund specific intervention programs to reduce infant and child mortality rates. How much of this funding is being used for research, and what type of research is it?

Answer. Through regular development assistance health funds, the Agency for International Development funds a portfolio of critically needed research in support of its child survival efforts. Research priorities include:

New and improved vaccines against common diseases affecting children in LDC's;

Improved ORS formulas; and

Better strategies and approaches for diagnosing disease and delivering child survival programs that reduce costs, reach more children and are more effective.

In fiscal year 1986, A.I.D. will commit $3,125,000 or approximately 6 percent of the $50 million specifically identified for child survival for high priority health research of direct importance to A.I.D.'s overall Child Survival Program. These funds will be used to support:

Project	*Millions*
936-5928, DDR (ICDDR,B and WHO/CDD)	$1.050
936-5952, Applied diarrheal disease research	.950
936-5935, DIATECH (diagnostic technology)	.875
936-5951, CSAP-Support (Johns Hopkins)	.250

Diarrheal Disease Research ($1.050 million).—Diarrheal diseases remain a leading cause of childhood morbidity and mortality and a major contributor to malnutrition throughout the developing world. Between 5 and 6 million children under 5 die each year of dehydration due mainly to diarrheal diseases. Oral rehydration therapy is an extremely effective technology to rehydrate children, but research on vaccines and other technologies to prevent diarrheal diseases must be accelerated. The additional Child Survival Funds will support targeted research at the International Center for Diarrheal Disease Research, Bangladesh and the World Health Organization on vaccines and other technologies that may help protect against diarrheal diseases.

DIATECH ($0.875 million).—This project focuses on the development of new diagnostic tools for diarrheal diseases, malaria and acute respiratory infections, which together account for approximately 80 percent of child deaths worldwide. The additional Child Survival Funds will accelerate development of simple diagnostic tools to improve the identification and treatment of these childhood diseases.

Applied Diarrheal Disease Research ($0.950).—The purpose of the additional Child Survival Funds is to accelerate the testing and adaptation of new techniques for the treatment of diarrheal diseases in children. This program of applied research with Harvard University provides the link between basic research on the control and treatment of diarrheal diseases and the needs of field programs to adapt research findings to local economic, cultural, and health conditions.

CSAP Support ($0.250 million).—Under this project with Johns Hopkins University, A.I.D. will support research to identify and evaluate improved strategies and approaches to the immunization of infants, children, and pregnant women. Priority is being given to studies related to measles, polio, and tetanus vaccines.

Question. I understand that the guidelines for use of the Child Survival Fund by private voluntary organizations indicate that only 10 countries will be considered for grants. How were those 10 countries selected?

Answer. A.I.D. has selected 22 countries in which it will concentrate its child survival efforts over the next 5 years in order to maximize the effectiveness and impact of its assistance on infant and child mortality. These countries, where child survival problems are especially severe, are the following: Bangladesh, Bolivia, Ecuador, Egypt, Guatemala, Haiti, Honduras, India, Indonesia, Kenya, Malawi, Mali, Morocco, Nepal, Niger, Nigeria, Pakistan, Peru, Senegal, Sudan, Yemen, and Zaire.

These countries were selected on the basis of the following factors:

Total number of infant and child deaths;

Infant mortality rates;

Immunization and ORT coverage levels;

Mobilization and absorptive capacity—including accessibility of population and availability of mass media and infrastructure;

Degree of government commitment to child survival, measured in terms of allocation of local resources and in terms of strong identification of local leadership—political, religious and other—with these efforts;

Availability of funds from development assistance, ESF, Sahel and Public Law 480 and opportunities for programming these funds;

Opportunities for effective donor collaboration aimed at achievement of common goals for improving child survival; and

Expectation that A.I.D. will continue to maintain a large program and sizable presence over the next 3 to 5 years.

In fiscal year 1986, ten of these countries—mainly in Africa—were selected for special central funding for PVO activities:

Africa: Kenya, Malawi, Sudan, Mali, Senegal, Cameroon, Nigeria and Niger.

Latin American and the Carribean: Bolivia and Guatemala.

The decision to place a strong emphasis on Africa was based on the high infant mortality rates in many African countries and the unique role that the PVO's can play in this part of the world.

In fiscal year 1987, the priority countries for central funding of PVO Child Survival activities will again be selected from the list of emphasis countries in the Agency's Child Survival Strategy.

Question. As of the date, 174 Members of the House of Representatives and 39 Members of the Senate have joined in supporting a $50 million increase in Child Survival funds for the Global Immunization Program. If those funds are made available to you, where would A.I.D. expand its immunization support efforts?

Answer. A.I.D. is committed to collaborating in an international effort to develop the sustained capacity to immunize the world's children. Specific features of A.I.D.'s immunization strategy include:

Concentration on 22 emphasis countries which account for two-thirds of all infant deaths in the world.

A primary target group of children under the age of 1.

Emphasis on high impact vaccines, specifically measles and polio for children and tetanus toxoid for fertile age women.

Emphasis on the development of institutional capacity to sustain host country immunization services.

Coordination with other donors, for example, WHO, UNICEF, and PAHO.

We believe that this strategy will permit A.I.D. to make the greatest progress with existing resources in extending coverage in A.I.D.-assisted countries. If the additional funds proposed were made available, A.I.D. would broaden its efforts in the 22 emphasis countries and consider adding additional countries primarily in Africa and Asia. In addition, we would consider increasing support for accelerated immunization and polio eradication efforts in Latin and Central America, and for activities with UNICEF, the Centers for Disease Control, and the Peace Corps.

Question. This year Congress has earmarked $8 million for vitamin A deficiency programs. We are very interested to see whether vitamin A programs will be as effective in other countries as it has been in Indonesia, where infant mortality was reduced by 23 percent.

As the Hunger Committee, we are just as interested in solving the long term problem of hunger by ensuring a nutritionally adequate diet of all the world's people as we are in solving the pressing emergency needs of today. My question is this: Are you taking steps to ensure that the long term solutions to vitamin A deficiency, such as promoting the production and consumption of vitamin A rich fruits and vegetables, are being pursued just as vigorously as the short term solutions, such as distributing vitamin A capsules?

Answer. The A.I.D. agriculture program, through research, technical assistance, and training, helps countries to develop improved crop varieties and agronomic practices and thereby increase productivity. This benefits the production of vegetables and fruits as well as other crops. More specific to vitamin A, A.I.D. has provided support to the Asian Vegetable Research and Development Center (AVRDC) to conduct a vitamin A garden outreach program in several Asian countries. Plans are under way to extend this program in fiscal year 1987 to selected African and Caribbean countries. The program encourages home and village production of locally acceptable green leafy vegetables and other vegetables and fruits rich in vitamin A.

A.I.D. also supports a strong education and social marketing effort to motivate people to consume foods rich in vitamin A.

Question. I am interested also in vitamin A fortification of foods distributed in the public law 480 title II program. I am aware that the powdered milk distributed to

mothers and children is fortified with vitamin A. Is A.I.D. considering expanding vitamin A fortification of other commodities distributed through the title II program?

Answer. All title II foods that have been developed specifically for young children are enriched with vitamins and minerals including vitamin A. These foods include wheat soy milk, corn soy milk, and instant corn soy milk. In addition soy-fortified bread wheat flour, wheat flour and soy-fortified cornmeal are also enriched with vitamins and minerals including vitamin A, since these commodities are often used in school feeding and preschool feed programs.

Most recently, we are testing the feasibility of enriching soy-fortified bulgur, soy-fortified sorghum grits and bulgur with vitamin A since the use of these commodities are increasing in programs for young children. The processors have already produced several batches with increased levels of vitamin A for USDA inspection. A.I.D. is currently reviewing the possibilities, both the need and technical feasibility, of increasing the vitamin A levels in all our processed cereal-based commodities. This review should be completed by the end of calendar year 1986.

Question. Last year the foreign operations committee report expressed concern that A.I.D. had too few health staff, both in Washington and in the field missions, to effectively administer the expanded health program Congress desires. For example, although the health assistance account has increased from $135 million in fiscal year 1984 to $192 million in fiscal year 1986, the number of health professionals has decreased.

What steps are you taking to expand your health staffing, as required in the appropriations legislation?

Answer. Currently, A.I.D. has approximately 80 foreign service and GS officers managing health programs in some 35 countries overseas. This figure, I should note, significantly underpresents the actual number of staff working on health programs. In additional to these health professionals, health programs in at least an additional 20 countries are covered by A.I.D. representatives, general development officers, and other technical staff.

A.I.D. also supplements our direct-hire field staff with foreign service nationals, personal service contractors, and institutional contractors in specific technicial areas. For example, we have an agreement with the Center for Disease Control that supplies more than a score of health experts in Africa, most of them working on immaunization programs. With reductions in direct hire technical experts over the past several years, A.I.D. has also developed several large centrally managed technical support contracts with leading health consulting organizations and universities. These organizations supply technical expertise to country and PVO programs in key areas of child survival, including ORT, immunization, and health communications.

We recognize that adequate direct-hire staffing is required to manage the Agency's child survival efforts, and we are monitoring the situation carefully. We know, for example, that in one or two of our emphasis countries additional staff may be required. We are taking steps to remedy these problems within the overall limitations that confront the Agency. We are doing modest recruiting in an effort to maintain our current staff levels in the health and population area including some entry level recruitment. I fully expect that we can meet our child survival goals.

[The prepared statement of Mr. McPherson appears at the conclusion of the hearing, see p. 42.]

Mr. HALL. Thank you, Mr. McPherson. I think the report that AID has put out on the Child Survival Program is a good report. It is very useful. I would encourage you to make it an annual report to Congress.

Mr. MCPHERSON. That would be our expectation.

Mr. HALL. In reading your testimony, I read several places where you say, "Political leadership must be committed to supporting these programs over the long haul and developing a base of popular support for them." Second, "Governments must make the hard budgetary decisions that will allocate scarce resources to sustain these programs on an ongoing basis." And, you concluded your report by saying, "We agree with this committee that 15 million needless child deaths a year is unacceptable. AID is determined to help solve this problem."

You have spoken of many important initiatives to improve children's lives in developing countries. You say don't cut the agricultural account, and yet you request a $70 million reduction in funding for these programs. You have had a good relationship with this committee the past couple of years, but it is becoming increasingly difficult for me on a personal level to understand, when I see these good looking reports, and I see some of the things you have done in the past, and yet year after year, you come to Congress requesting decreased funding, and it is incumbent upon us to initiate increased funding. It is increasingly difficult to do it around here, even though we have tremendous bipartisan support. You are the advocate in the administration for these programs that we are talking about today.

Yet, it seems as if we have to go it alone here in Congress all the time to try to increase these funds. I know you are a supporter of these particular initiatives—health, nutrition, ORT. We are, too. Why are you requesting $70 million less in fiscal year 1987?

Mr. MCPHERSON. Well, part of my response a moment ago, Mr. Chairman, was that I feel I have to go it alone sometimes on the agriculture money to feed children.

Let me respond a little bit more to your question. I think that for Congress to cut $100 million for agriculture last year when we needed that money in the middle of the drought is something Congress ought to think about. There is a balance to be maintained.

For example, in Sudan, which suffered the terrible drought last year, we have been able, over the last few years, to develop a sorghum variety that increases yields by 100 percent. I am now putting about $75 million a year into research in agriculture in Africa to develop other new varieties. I think in the next 6 to 10 years we will be able to get new varieties which like that sorghum, have similar impacts in many places in that troubled continent. This is very important, and when Congress cut the agriculture account by $100 million and increased health, I wonder why there is such short-term thinking. I really do, particularly when you look at how I have been able to use funds from other accounts.

Look at Egypt. I have been able to put $26 million into ORT in the last couple of years, and I am about ready to put in another $73 million into child survival overall. My appeal to you would be, Mr. Congressman, help me with the agriculture account, because when you look at the overall numbers, you will realize that I am putting plenty into this. Don't look at the narrow little number on health because in 1985 on child survival overall we put in $183 million. In fiscal year 1986 we put in $111 million for ORT, immunization, and related research and $160 million for child survival overall. For 1987 we talk now about $121 million, but I am confident this will turn out to be even higher.

I submit to you, Mr. Congressman, Mr. Chairman, that we have maintained an increased commitment to child survival, not just because Congress wanted us to do so. We arranged for ICORT I; that was my own personal initiative. We have pushed hard on ORT more than on immunization, in part because more children can be saved with ORT than by immunization. But, I think, they are both very important, and we now have this twin-engine strategy.

We are putting money there plus, we need your help on agriculture. Don't just look at a narrow number or at a narrow glamorous issue. Agriculture may not bedazzle but, as the Hunger Committee, you are a group whose support I need in dealing with these issues.

Mr. HALL. First off, Mr. McPherson, this is not an appropriation committee. This is a select committee, and second——

Mr. MCPHERSON. Mr. Chairman, I know how you can mobilize things.

Mr. HALL. Second, this committee is firmly behind what you are talking about relative to agriculture, and we are advocates of that. We didn't cut that figure.

Third, when you talk about the agriculture account, you mean appropriation of $755 million in 1985; in 1986, $669 million; in 1987, $709 million. However, for health you requested only $150 million in fiscal year 1987.

My point is you have changed the subject on me. I ask you about health, and you told me about agriculture. We are interested in health and nutrition, and that is what this hearing is all about. And we want you to be the advocate that you were 2 years ago. We want to know why you are seeking to cut $70 million. We will help you in agriculture, but you need to help us in this particular area. You are the only advocate we have got in the administration on this particular issue.

Now why are you seeking $70 million less in funds when in fact many of the PVO's, the private voluntary organizations are requesting more money. Many of us travel in various countries—I have been to Zimbabwe. I have been to Uganda. I have been to Kenya. I have been to Mali, Ivory Coast, Ghana, Ethiopia. You are cutting down your staff in the field in health aid. The Appropriations Committee is pressing you for more health professionals in the field, and you want to talk about agriculture.

I want to help you with agriculture, but you tell me about health.

Mr. MCPHERSON. Mr. Chairman, I think I did respond in part about health, but now let me respond in detail. First, I am not cutting back. I am cutting back from what was appropriated but I am increasing what the administration requested. What we have done, because Congress clearly has an interest in this, was cut agriculture some for 1987 requests and increased health some for 1987 requests. We didn't go as far as Congress did last year, but we went further than we had gone the year before.

We thought Congress went too far last year, given the balance that I have to maintain—the reality that I face. Look at it from where I sit. From my point of view, I have a certain amount of development assistance. We can argue as to whether the development assistance account should be bigger or smaller or whatever else, but, in fact, it is no easy trick to get a DA account of a couple billion dollars.

Look what happened on the Senate floor yesterday afternoon where $160 million or so was cut from foreign assistance. It is tough. I have a couple of billion dollars or so to deal with—how do we divvy up that? That ultimately is the issue, and I submit that I can get a good deal of health money in various ways—the ESF account, Public Law 480 local proceeds, et cetera. We don't even

have those added in here. This is the kind of balance that I have tried to strike.

With all due respect, in responding to Congress, I somewhat cut the agriculture account for 1987 and increased the health account for 1987 over the numbers which we had submitted to you for 1986. It may not go as far as you want, but I honestly tell you that the balance that you have proposed for divvying up the DA account is not right; that the balance which we have submitted for that account, since we are going to get only a certain amount of money, is the balance we ought to have. We may disagree about that, but that's where I am, and I think properly so.

Now, regarding health professionals, because our operating expense [OE] account is reduced in real terms and adjusted for inflation, we have cut AID staff around the world by several hundred persons. We had no option but to cut those staff; that is the number that Congress gave us. Last year Congress gave us what we asked for, incidentally. The year before we were cut some.

Over the 5 years I have been here, we have reduced staff by about 8 percent. Almost all of that 8 percent reduction has been in Washington. That is a key point, Mr. Chairman, that I have reduced staff in Washington, not in the field. It was a very conscious decision. I felt there was a middle layer of Washington management that I could cut out. We were a better agency to do that, I thought. We have decentralized our decisionmaking so people in the field have more authority, more ability to do things.

Health staff size is less than we would like it to be. We would like more of them. AID has approximately 80 foreign service and GS officers managing health programs in some 35 countries overseas. How have we adjusted for this problem? Well, we have funded, health professionals out of various project moneys. For example, we have an agreement with the Centers for Disease Control in Atlanta that has health staff assigned to a number of our projects, some 22 professionals. It is a struggle for us to be able to keep up our professional numbers.

We want to keep you closely informed. It is one of the major management difficulties I face with the child survival implementation. I think we are making real progress, though. The Centers for Disease Control approach is a good one, and we think we will reach similar agreements with some universities as well; for example, other providers like Johns Hopkins. So there I am on numbers of health professionals.

I ask you to look at the numbers in terms of my overall budget, and I believe you will agree that I am responding tremendously within the constraints I have; $111 million for child survival is a pretty good number this year. I believe this; I don't just say it. Ask my mission directors from anyplace in the world whether McPherson believes in child survival, and whether they think that their career path needs to keep in mind child immunization and ORT. I am convinced they do. I think we are increasing our numbers and a year from now they will be, I think, even higher. We need your support, and I appreciate the opportunity for me to candidly respond to your interests.

Mr. HALL. Mrs. Roukema.

Mrs. ROUKEMA. Thank you, Mr. McPherson.

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I think your twin engine strategy, of course, is well devised. I do not question your sincerity of purpose, nor your effectiveness within the administration. However, I don't think that anything this committee has said, spoken either by the chairman or by me on behalf of the Child Immunization Program, should be interpreted as a desire to fund one sexy issue at the expense of another. It is certainly not our intent to take away from a fundamental program such as ORT or the Basic Feeding Program.

Now, I understand that you have a difficult problem. You are a person who understands the totality of the issue, and yet as a spokesman for the administration in these austere budgetary times, I know it is an excruciatingly painful position for you to be in.

Let me just say, and I think this may be the chairman's point here, that I would hope you would have a good knock-down-drag-out argument with OMB before you ever make your presentation to the Congress. I think you probably have, but we would like to support you in a higher profile advocacy position if we may. OK?

I think that is the message that the chairman is getting across, and certainly I support him in that area. But we understand that there are certain fiscal realities. Now you have quoted some figures here. Is it $111 million that you have indicated for next year?

Mr. McPherson. This year.

Mrs. Roukema. What does that buy us in practical terms as far as the twin engine strategy that you have talked about.

Mr. McPherson. Well, we are focusing on 22 countries—as our primary focus. With ORT, however, we have programs of varying sizes in more than 50 countries. We have had ORT as a major initiative for a few years. In immunizations, not as many, but that number will climb rapidly.

Mrs. Roukema. Wait a minute, can you be a little more specific about immunization, not so many, but the number will climb rapidly?

Mr. McPherson. I mean not so many countries.

Mrs. Roukema. Oh, not so many countries

Mr. McPherson. Though this year we are going to be spending $53 million on immunization, so about half that $111 million will be immunization, $37 million on ORT. ORT is probably a little cheaper per child reached, but you have to reach the child again and again with ORT.

What I am trying to do, and I think this will help the committee, and help us all sell this, is pursue global targets that I spelled out at the ICORT II conference: A target, for example, to save 2 million children by the end of 1990; as well as global goals for immunizations that UNICEF and WHO have spelled out. I think what you need to do to get this job done is to translate those global goals into targets for countries. You need to do so realistically.

In Egypt, for example, we can do big things, set ambitious goals. We have a lot of money. We need to say for Egypt—"we saved 90,000 lives with ORT, now where will we be in 1990 or 1991 or 1992 on ORT? And where will we be with immunizations?" We need to work out these country-specific goals with our individual missions. We need to be realistic given the amount of money that we have and we need to hold our mission directors accountable.

There may be changing circumstances, but these are the kinds of tools, management by objective, that we are shaping.

Another reason why I want to do this is because if we can work out realistically goals with and for Ecuador, we can better approach the World Bank and the other major donors of Ecuador. Then, we as a donor community, together with UNICEF and WHO, we can commit ourselves to these goals, and mutually reinforce each other as we go along.

That is what I am pushing to get done. So I guess that is the answer to your question, when you say where are we, that is, where are the dollars. In some countries like Honduras and Egypt, we have already got fabulous results. But what I am going to be interested in is setting it up so that in 5 years, let's say, another Administrator can sit here and be able to say to this committee, "Well, here is what we did over the last 5 years. Here are our goals, and here is how we measured up, and here is how we didn't measure up."

Mrs. ROUKEMA. Is it on a straight line target to the achievable goal of immunization by 1990? Is it a straight line projection based on what we are doing next year?

Mr. MCPHERSON. What you are going to see with both immunization and ORT is a line that goes sort of like this, but then ought to take a leap up. Therefore it is not straight. It is not straight because in the end the sustained deliverability of immunization will depend upon whether you built the infrastructure to do it, and so a disproportionate amount of energy now is put in to building this delivery system.

There is a real difference in the world. This is not just a figment of our hopes. The facts are that in a number of countries—I mean you have in Egypt 30 percent fewer children dying today than you did in 1981 or 1982. That's something, 30 percent fewer children. That's real. In Honduras the death rate has dropped markedly, about 20 percent.

Mrs. ROUKEMA. I'm glad to hear those figures, and I am also glad that you close on that note of reality because I had intended to commend you for stressing the point about sustainability. It deserves to be stressed over and over again that the other component to our immunization program is to build a sustained delivery system. One cannot function without the other. I appreciate your testimony. Thank you very much.

Mr. HALL. Congressman Kostmayer.

Mr. KOSTMAYER. Thank you, Mr. Chairman.

Mr. McPherson, your agency recently sent to Peru a large shipment of ORT packets, some of which caused some infant deaths, and I am concerned about—well, let me read you a quotation from the Atlanta Journal:

> The incident has triggered an internal AID investigation into how a small relatively unknown company which, one AID official said, had manufactured the salts in a garage, was able to win the contract. Another AID official said that it was the first time U.S. Materials—that's the name of the company in New York—had won an agency contract and manufactured the salts, and that little is known about the company except that it was a small operation. The official added that AID does not maintain a list of approved companies allowed to bid on its contracts.

I share the concern I know you share about this and what is being done about it, and the problems of retrieving these packets especially in rural, isolated areas of the country. I would like you to respond and tell the committee how you plan to cope with that problem, but in a more general sense why, in your judgment, this happened.

Mr. McPherson. There are probably a couple hundred million users of—I think that is the figure that Jim Grant has been using at UNICEF—users of ORT around the world 1 year now. To our knowledge, this is the first time that there has been a problem. Obviously we are deeply concerned. It is not yet clear that the deaths were caused by the ORT, but what we do know is that some of the solution from one batch clearly had higher potassium levels that would have been dangerous if they had been consumed.

Mr. Kostmayer. Well, just to interrupt, the FDA did open some packets and found, and I quote again: "dangerously high levels of potassium," in two packets, but nothing unusual in two others. So you are right, it is not definitively known yet, but it is clear from opening some of the packets that they——

Mr. McPherson. That's right. We brought FDA into it.

Mr. Kostmayer. No, I am not quarreling with that.

Mr. McPherson. We were anxious to find out just what the case is, and we continued to test packets from around the country, and it has been only from this one box or batch that we found.

You have a couple of issues here. One, I think, is that it makes everybody sit up all around the world and say, "well, how come?" We have all viewed ORT as really quite safe and easy. In fact a lot of ORT is home mixed. You get a handful of sugar, and a pinch of table salt, and mix it with water, and it works almost as well as the factory-made variety, frankly.

We have all taken careful note of this. We went immediately to the health ministry. The health minister took the lead in trying to get back all the packets in the country. This was from a purchase of a couple of years ago.

Obviously, the question that we ask is, what happened? What about this contractor? Should we ever have contracted with this person? As background, you should note, we have become, as I mentioned a moment ago, a very decentralized agency. I felt that the Agency wasn't responding fast enough to problems. Washington was controlling things too much. I think the decision to decentralize was right, and I stick to that. This procurement was a decision made a few years ago in the mission in Peru. The so-called diarrhea season was approaching. It was hot, a time when we expected to have the most kids with diarrhea, and they didn't have enough salts on hand.

The mission there let out a bid, and the lowest responsive bidder was this company. Then the salts came in and were used. We are still looking at the procedures that were used and the decisions that were made. I intend to take whatever appropriate action is necessary concerning the judgments or the procedures, and I expect to get that kind of thing satisfactorily resolved.

Mr. Kostmayer. I guess I have a feeling that I really haven't gotten an answer to my question. Do you maintain or do you not

maintain a list of approved companies allowed to bid on AID contracts?

Mr. MCPHERSON. We do not maintain a list of approved companies to bid on ORT contracts. ORT to date has not been considered a drug by either FDA or by us, and as such, it is like any other commodity, goods, or service that you might bid or provide for.

Mr. KOSTMAYER. Do you think that policy ought to change?

Mr. MCPHERSON. I think that in some way the procedure ought to be different in terms of either testing what we are provided or restricting who can bid, and we intend to take some combination of these steps, yes.

Mr. KOSTMAYER. So you maintain a list of approved contractors for drugs, medicines that are used, but not for nondrugs.

Mrs. ROUKEMA. Would the gentleman yield? I just want to ask a question of clarification, Mr. McPherson. You indicated that the mission in Peru directly bid.

Mr. MCPHERSON. Directly proceeded to offer the bid.

Mrs. ROUKEMA. It is the standard procedure that any individual mission can make its own arrangements either with a company in the United States or otherwise?

Mr. MCPHERSON. That's correct.

Mrs. ROUKEMA. And this is consistent with your decentralization program?

Mr. MCPHERSON. Yes; if you didn't do that, then everything would have to go back to Washington and could take weeks longer. Officials in Peru realized that thousands of children would die if they didn't have the ORT on hand, and they moved quickly.

Mr. KOSTMAYER. I'm not sure why—I'm sorry.

Mrs. ROUKEMA. No, go ahead.

Mr. KOSTMAYER. I'm don't understand why it would take longer to run it through some central unit in Washington. It seems to me——

Mr. MCPHERSON. It always does.

Mr. KOSTMAYER. It seems to me if you have got every mission with a procurement officer and every mission bidding on contracts all around the world, rather than being done. That is an administrative question, and that is not what I am interested in, and I confess you don't seem as astonished as I was sure you would be. This stuff was mixed in a garage somewhere, apparently, according to one of your people. I think that is extraordinary, don't you?

At least four children died. I know you share my concern over that, obviously, and I don't mean to imply you don't. I think it is a very serious situation.

Mr. MCPHERSON. Well, I think that in fact it was my judgment that this contractor probably should not have been selected, and other steps in terms of quality control may have been appropriate.

Mr. KOSTMAYER. At least for ORT, there is no quality control now at all. AID, an agency of the U.S. Government, can buy this stuff mixed in a garage somewhere by some charlatan and distributed to children. It happened.

Mr. MCPHERSON. Ordinarily there would be quality control by the company, and my judgment is that this is a truly extraordinary circumstance; we have thousands and thousands of bidders on AID contracts. I think that when we get all our facts established, we

will be able, very shortly indeed, to take positions concerning the judgments that were made and the procedures that were followed. It is my belief that I will have procedures in place that will prevent this from occurring again, which is the bottom line, I think.

I don't want to pull everything back to Washington. I found that it took me months longer to get things done if I had everything in Washington.

Mr. KOSTMAYER. Well, no one can accuse you of concentrating things in Washington.

Mr. HALL. Excuse me just a second. Mr. McPherson has been here a little bit over an hour, and I realize that we don't get a chance to see Mr. McPherson often, and we all have a lot of questions for him, and some of our questions we want to submit to you. I'm sorry, one more question. We have a number of witnesses to come after Mr. McPherson, so we need to move more quickly.

Mr. MCPHERSON. Maybe I can give shorter answers.

Mr. KOSTMAYER. I appreciate that.

Mr. HALL. Let's try to have shorter answers.

Mr. KOSTMAYER. I'll try to ask shorter questions more quickly.

Mr. McPherson, let me ask you about your attitude toward the UNFPA and whether or not the administration's attitude is changed, whether or not AID's attitude is changed. I know you have asked for $32 million, which is a reduction from what we have been spending on the past on that important family planning program. You have virtually eliminated $17 million from the International Planned Parenthood Federation all together. You know my feelings on that.

A number of my colleagues are now pressing you to eliminate entirely, rather than just reduce as you have, funding for family planning in the poorest parts of the world, and I am anxious to know whether you are going to comply with those elements in the Congress as you have so willingly in the pass, or whether you are going to resist.

Mr. MCPHERSON. Mr. Kostmayer, I don't think I have complied with all those elements.

Mr. KOSTMAYER. Tnat's what makes vanilla and chocolate, I guess, Mr. McPherson.

Mr. MCPHERSON. I think that we can be pretty proud of what we have been able to do, and I know you feel very deeply and strongly and have worked very effectively on this issue. We can be quite proud of the fact that the administration has always asked for at least as much money as they did the year before or more, and that during the Reagan administration, the family planning numbers, no doubt with some real help from Congress, have climbed, so that we have spent a lot of money on family planning these last several years.

Mr. KOSTMAYER. You have cut IPPF entirely. Our $17 million contribution to the International Planned Parenthood Federation has been wiped out by the Reagan administration with your concurrence.

Mr. MCPHERSON. That is correct.

Mr. KOSTMAYER. No way that that is more than last year.

Mr. MCPHERSON. That is correct, and I won't go through the reasoning.

Mr. KOSTMAYER. I can see why you wouldn't want to.

Mr. MCPHERSON. I would be happy to if you wish me to. The gentleman says I can't talk long.

Mr. KOSTMAYER. I am not a good mathematician, but there is no way that that is more than last year. You have eliminated the program, and you have reduced UNFPA.

Mr. MCPHERSON. Mr. Kostmayer——

Mr. KOSTMAYER. You have so little time, instead of talking about the mistakes you have made in the past, why don't you tell me about the mistakes you are going to avoid in the future.

Mr. MCPHERSON. The UNFPA program is one that I feel is an important one, that I would hope that——

Mr. KOSTMAYER. That is a bad sign. That is what you said last year before you cut it.

Mr. MCPHERSON. —that we can in fact put money into UNFPA, but per the position I took at the end of last year, we will do as follows: One, we can provide money to UNFPA if the circumstances in China, the Chinese Program, are different.

Mr. KOSTMAYER. Well, have they changed, to sum up, because as the Chairman said——

Mr. MCPHERSON. I don't believe they have changed. Or alternatively, we can provide money to UNFPA if UNFPA provides money to China for different things.

Mr. KOSTMAYER. Only for contraceptives.

Mr. MCPHERSON. Only for contraceptives or health or something such as that.

Mr. KOSTMAYER. That would avoid a cut if they were willing to use their share only for contraceptives?

Mr. MCPHERSON. That would mean that legally we could provide it.

Mr. KOSTMAYER. OK, thank you.

Mr. MCPHERSON. Legally we could provide it, which isn't a policy decision. Legally, in my judgment, we can provide it if they provide only contraceptives.

Mr. KOSTMAYER. Thank you.

Thank you, Mr. Chairman. Sorry to be a hog.

Mr. HALL. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. McPherson, I want to go back to your brief comments earlier about the cut in agricultural funds to say that this is an area of particular interest to me, probably more so than to some of my colleagues on the committee. I share some concerns, and you seem to express some puzzlement as to why we should cut this when it is so important to be able to feed children, if you are going to save them through some of these other devices.

I would just caution you and tell you one of the reasons why I think there is a tendency to do that and to try to make sure that you understand the feeling of my constituents. I represent an agricultural district where agricultural exports are extremely important and where the basic feeling of those people is a horror at the thought of a famine and starvation around the world and the great willingness to help with solving those problems.

But they get very distressed and very emotional when they discover that some Third World country has been helped by the

United States in the AID to develop the ability to export crops which compete directly with us, and particularly when those crops have very little to do with the feeding of that population. I guess one of the classic examples, and there are many, and I don't—I know our time is limited—is palm oil, where we, in the past at least, or other agencies to which we have contributed have made it possible for these countries to develop further substantial plantations of oil palms, and this is come back to haunt us in this competitor in our soybean and soybean oil market.

To get to a question now, are we watching that more closely?

Mr. MCPHERSON. I think we are, Mr. Evans.

Mr. EVANS. Focusing in on helping those people to be able to feed themselves as opposed to helping them develop crops that are for export.

Mr. MCPHERSON. I am really very aware of this issue. I grew up on a farm in Michigan, and in fact I still own some farm land back there, and I am very conscious of this as a problem.

The policy that we pursue and have been pursuing for a few years now, and one that I have been sensitive to for some time, is that it is one thing to help a country be able to better feed itself, and I think Americans support that. It is another thing to help a country so it can export and compete against our own folks.

Now, if we do that right, what we find is that the export market within the developing world increases. For example, in Korea we used to give them all that good grain growing out there in Iowa for the Public Law 480 Program. We did so for years, but now, as you know, the grain we are exporting to South Korea, which is bigger than all the previous Public Law 480 years combined, is not for people. It is for animals. It is feed stock. And by and large if you can increase the level of per capita income, you are going to have more food imported into most of these countries, a different kind of food.

Mr. EVANS. I know the chairman wants to move on, so I don't mean to press this, but I think you must be very conscious of this if you want support for your agriculture programs, at least in the agriculture sections of this country, and I am reassured by the fact that you are aware of it, and I hope you will continue to emphasize that.

Thank you, Mr. Chairman.

Mr. HALL. Thank you, Mr. Evans.

Mr. McPherson, thank you again for coming to this committee. I have some more questions I would like to ask you, but if I could, I would like to submit them for the record.

Mr. MCPHERSON. I appreciate the opportunity, and I appreciate the opportunity for talking to you directly about these issues. Thank you.

Mr. HALL. Thank you.

We have two witnesses coming up, and we would like for both of them to sit before us at the desk. The next witnesses are Lynn Redgrave and Dr. Jolly. Lynn Redgrave, of course, as you know, is an excellent actress and a very effective spokesman for UNICEF. Following her presentation, we will hear from Dr. Richard Jolly. He is the Deputy Executive Director for Programs for UNICEF.

Dr. Jolly, why don't you come up, too, please. And I would like to make it clear that Dr. Jolly's appearance today does not constitute a report to the Congress, rather this is an occasion in which we are able to profit from the information Dr. Jolly is sharing in order to raise public awareness of UNICEF's contribution to child survival and development. So with that, Ms. Redgrave, we would appreciate your statement on this most important program.

STATEMENT OF LYNN REDGRAVE, ACTRESS, U.S. COMMITTEE FOR UNICEF

Ms. REDGRAVE. Thank you, Mr. Chairman, for the opportunity to come here today to comment on the tremendous importance of your support for the health and well being of the world's children and their mothers.

For the record, my name is Lynn Redgrave. I am a mother of three children, and I am the spokesperson for UNICEF's 1986 Mother's Day campaign. I am visiting six cities in the United States before this Mother's Day, May 11, and trying to raise consciousness and of course raise money through the selling of the Mother's Day cards, and the money from those cards is of course specifically targeted toward the Universal Child Immunization Program.

I am at the same time drawing attention to the four means of making this project so helpful: ORT, growth monitoring, breast feeding, and of course, immunization, as I have said. Today I am, I suppose you could say the token mother and am speaking to you on their behalfs.

We have the opportunity to cut in half the deaths and disability rates of the world's children down from the staggering 40,000 per day, to the equally disturbing 20,000 per day by the end of the century. The technology is available, and the political support is growing every day, but the key to the success of our efforts rests squarely on the capacity of the parents, primarily the mothers, to learn and apply the know-how that is necessary to prevent premature death from diarrheal disease or blindness from lack of nutrient rich foods or bronchitis and other acute respiratory illnesses so common among the malnourished children.

The world's mothers stand at center stage in the global mobilization of human and financial resources to bring the pain and the disability of the children to an end, and as you consider the proposals for improving your Child Survival Action Programs and activities, please remember the mother. Today, as you know, in the developing countries, women work more hours per day and more days per year in the fields than men, and they are responsible for producing more than half of all the food grown in the developing world.

Of the 460 million women in the developing world, no less than half are estimated to suffer from energy sapping anemia. An estimated total of a half million mothers die each year from causes related to child bearing. Maternal mortality rates in some developing countries are up to 200 times higher than in Europe, leaving several million motherless children.

The assistance that you can provide to the world's mothers will make the difference in the future that our children will inherit, and we trust that that future will be one that we can all be proud of. Thank you.

Mr. HALL. Thank you, Ms. Redgrave. We sincerely appreciate your time and share your concern for this most important program. One of the concerns that we have here is that the media has stopped focusing on this issue.

There are still going to be 15 million children that are going to die this year, and we really need effective spokesmen. We just appreciate you and people like you who take the time to go around the different cities and visit the countries and tell us, and tell the people that the problem is not going to go away. It is going to be here, and we need to attack it. Regardless of whether there is focus on it from the standpoint of media or whatever, we need to continue to remind people that it is here. We just thank you for taking the time to come here.

We are going to go to Dr. Jolly. I understand that you have an appointment someplace in the District and that you might need to leave here by 11:30. If you do, feel free to leave at any time.

Ms. REDGRAVE. Thank you very much for the opportunity.

Mrs. ROUKEMA. Ms. Redgrave, if you do have to leave, I do not want you to do so before I personally have the opportunity to thank you for your efforts. I admire the work you are doing, and that comes from one token mother to another.

Ms. REDGRAVE. Thank you very much.

Mrs. ROUKEMA. I think you are doing a very very important job in making the direct link between the health of the mother and the health of the child. I thank you for your articulate statement.

Ms. REDGRAVE. Thank you.

Mr. HALL. Dr. Jolly.

STATEMENT OF RICHARD JOLLY, M.D., DEPUTY EXECUTIVE DIRECTOR (PROGRAMMES), UNICEF

Dr. JOLLY. Perhaps I should say for the record my name is Richard Jolly, and I am Executive Director for Programs for UNICEF, and without in any way taking away from the previous two statements, perhaps I can say I am a father of four. UNICEF is endless it its commitment to mothers. It does also recognize the important role that fathers also have to play.

Mr. Chairman, I feel privileged to present evidence to this committee with its important interests and declared commitments. In doing so, I respectfully express best wishes from Mr. James Grant, the Executive Director of UNICEF who gave evidence to this committee, I think, 2 years ago and to Dr. Stephen Joseph, who gave evidence a year ago.

Mr. McPherson, the U.S. AID Administrator, has just spoken of the twin engines of the child survival: ORT and child immunization. I am happy to confirm here UNICEF's strong commitments, indeed major program focus on these and also our commitment to working closely with U.S. AID as well as with the World Health Organization and other bilateral agencies towards these goals.

I would like to begin my statement, not with the solutions, but underlining something of the problems and to emphasize the broader aspects, the broader context in which nutrition, as well health problems are set in the world today. Then I would like to come to something about what can be done about it, and emphasize again several broader areas of action relating to nutrition. Finally, I would like to state something of what has been achieved in the area of health and particularly ORT and immunization over the last 12 months or so since Dr. Joseph gave evidence.

Mr. Chairman, the 1980's will, I fear, almost certainly be recorded by future development historians as the decade of rising poverty and malnutrition in many, if not most countries of the world. Certainly this is true for the vast majority of countries in Africa and Latin America. It is probably true also for many of the better off countries in the Middle East, even in the United States, Britain, and some of the other industrialized countries poverty has been rising, and often malnutrition among the poorest as well.

Only in the economically dynamic Asian countries can one be reasonably sure that malnutrition and poverty are declining rather increasing both as regards to the proportion of the population affected and as regard to the depth of the poverty and malnutrition they experience. What has been happening in the majority of countries is the widespread and marked deterioration in the human condition. The situation is one of a worsening of poverty and malnutrition, not merely as for so long before, of its persistence, nor as often before, is it a matter of worsening poverty in some countries with improvements in others.

The early 1980's have, for various reasons, produced a strong, sustained a systematic set of downward international pressures on the majority of developing poorer countries with the consequence that living standards have very seriously deteriorated. There is still time for change. UNICEF believes in hope, but without action, the second half of the 1980's will be little better than the first half.

Statistical data on nutrition is rarely collected systematically so that the evidence available is far from comprehensible. Nonetheless, we have, since 1980, evidence from various parts of the world that moderate and serious malnutrition has risen considerably. I could give examples from perhaps 10 countries in Africa, if one actually needs examples in terms of what we have seen on the television programs last year.

But I would stress with respect to Africa that it is not merely the problems of drought, serious though they were, it relates also to the more persistent problem of financial drought, the extreme scarcity of resources led by problems of exports, export earnings and prices, rising debt payments and so forth, which has led to a total economic squeeze on the majority of countries in Africa.

One could say similar things about Latin America. The prime cause of hunger and malnutrition is low incomes, as the recent excellent World Bank publication, "Poverty and Hunger," reports. But it is when low incomes combine with declining incomes and poor health that the worse manifestations arise. The economic crisis has reduced household incomes and also reduced Government's capacity to provide health services.

Mr. Chairman, I would like to underline the number of countries for which this is true, because too often we see averages for Africa or Latin America, and we don't see how those averages are working out in terms of the number of individual countries that have been suffering negligible or negative economic growth. In Latin America, for example, 17 out of the 23 countries, experienced negative cumulative growth of per capita income. That is a strange way of putting a decline, in average incomes, in 17 countries between 1980 and 1985.

In Africa, three-quarters of the countries had persistently negative growth of per capita income during the 1980's. In 1985 in Africa, 25 out of 32 countries for which we have data had either negligible or declining growth. For Africa as a whole, GDP per capita in 1985 was 15 percent below that in 1980, and the latest World Bank projections expect that to continue negative for another 10 years. Only Southeast Asia did significant growth occur in most countries in the 1980's.

Mr. Chairman, I will skip, for the sake of time, some of the details, but let me summarize the mechanism at work which was revealed in a study that UNICEF undertook 2 years ago wherein a situation in which what we described as a reverse shock absorber effect was operating. Instead of international and within developing countries national mechanisms existing, which absorbed the results of these declines in income, usually the process is transmitted with a multiplied effect, particularly on the poor and because the poor tend to have larger numbers of children in their families, in a multiplied way on children.

In particular, incomes and employment of individuals have fallen sharply often by 20, sometimes 40 percent, and usually more so for the really poor families. Similarly social expenditures in health, in education, are the vital parts of social services, also have decreased; sometimes disproportionately, always in relation to the average of decline. This, Mr. Chairman, is the challenge which provides the context in which malnutrition appears in many many countries to be on the rise.

Mr. Chairman, there have been some recent developments which improved the outlook and the outlook particularly for what is called adjustment policies; those sets of macroeconomic policies which countries adopt to cope with declining incomes and particularly declining foreign exchange and rising debt. In the first place, the sharp fall in oil prices has somewhat eased the problems of oil importing developing countries, although, of course, this will have other effects on the exporting countries.

The international climate, I would like to emphasize, has also improved substantially with moves to support growth oriented adjustment led, indeed, by Treasury Secretary James Baker. There are other signs of national and international thinking with respect to adjustment debt and the need for more emphasis and support for longer term development, but here I come to the point which, with respect, I think needs to concern this committee. Growth in these countries alone will not deal with malnutrition nor poverty. That was the lesson of the 1960's. That led in the early 1970's to this goal for attention to poverty eradication, to meeting basic needs in

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developing countries, to concern with equity as well as with growth.

This is what we have seen lost over the last 5 to 8 years internationally whatever may be happening nationally. And it is that which UNICEF believes—this was underlined by our executive board last week. It is very important to bring back the emphasis on the human dimension with this concern for adjustment. UNICEF describes this as adjustment with a human face. The need to give explicit attention to meeting the nutritional needs of the population and other basic needs of vulnerable groups in the course of adjustment policy.

It is not only a human imperative, it is also sound economics to insure the conditions for long-term economic development. Human beings are the most important economic resource investment in health and education can offer, as it has been demonstrated, positive rates of economic return and healthy, well-nourished and educated children are the obvious cornerstone of long-term economic development. Adjustment with a human face is multipronged. It requires action to maintain, and if possible, increase incomes and productivity, especially of low-income households, both rural and urban during the adjustment process.

It requires monitoring of nutritional standards and special interventions to help maintain standards where necessary. It requires restructuring of Government expenditures to protect social expenditures and to restructure within social expenditures to the high effective areas, for example, the immunization, the oral rehydration and equivalent actions in health and other sectors. It requires attention to services focused particularly on low income families and the deprived.

The precise action needed will vary according to country circumstances, but a critical requirement for all countries is first to accept the protection of the nutritional status should be an objective in adjustment policy. It is not just a financial arrangement. It is critical, and second to insure some process of monitoring to see whether those nutritional goals are being achieved or not, and if not, how action can be taken.

Mr. Chairman, again, for the sake of time, I will miss out examples, but UNICEF believes in arguing from practice not just from theory. I quote some very interesting examples in Botswana, where over the last 5 years, in spite of one of the worse droughts in that country's history, they have maintained a very effective broad based set of programs focused on nutritional support for all categories of the population beginning from the young child, the pregnant and lactating mother, but also for able-bodied males and in many ways working through the marketplace in a very effective fashion.

Burkina Faso has shown that a very low-income country can take dramatic action to improve the health of its children. As the minister will soon be presenting evidence, let me just say it is a wonderful story, and UNICEF has been proud to follow that, and in a very modest way to provide some support. I also give examples of Tanzania, Zimbabwe, Ghana, South Korea, which has introduced within its own economic policy many excellent child focus programs; and in the Philippines where the new government, as was

personally expressed only 2 or 3 weeks ago, is very keen to tackle their own poverty problems and rising malnutrition problems in many parts of the country with an openness confirmed by the President and with a determination to action. There is a lot of areas there calling for international support.

Mr. Chairman, let me end by showing the linkages between the broader context of nutrition and adjustment with a human face and the more specific actions that we have talked about already this morning under the heading of child survival or child survival and development, as UNICEF puts it. Child survival and development action essentially consists of widespread promotion of low-cost health measures which can massively improve child health. The significance is the low cost makes them possible as mass coverage measures in spite of the economic constraints, so they are ideal in this situation, and they are also examples of the sort of actions that need to be given more emphasis in spite of the cutbacks.

This, indeed, what we are proud and pleased to see has actually happened. Many members of the select committee are familiar with the opportunities and the dramatic progress it has indeed been made and have, I think, probably seen the "State of the World's Children Report 1986" as well as the excellent U.S.A. publication, "Child Survival, a Report to Congress" on the Aid Program published last December.

Let me underline the statistics as of March showing what actually has been achieved. Over the preceding 18 months to March this year, some 61 countries have now prepared, and in many cases embarked upon, serious plans for achieving universal child immunization by 1990. World vaccine use—and I would add that that includes 20 of the 26 largest countries in the world, in other words, countries with 20 million population or more. World vaccine use in 1985 was three times the level it was in 1983. Salt use, oral rehydration salt use, was 2½ times the level of 1983, 8 times the level of 1980 and 250 times the level of 1974 when it was roughly 1 million packets.

I would stress that these increases are at a time when the economic indicators, and often the health budget indicators, have been negative, so we have seen this dramatic increase implying this restructuring of the salt we need. Perhaps the bottom line, drawing on WHO data, UNICEF estimates that 1985, something more than 1 million fewer under age 5 children died because of the immunization and ORT efforts alone. These are remarkable achievements at a time of severe economic constraints and show the beginnings of a restructuring within health expenditure so badly needed, and which we believe needs also to be carried through now into other areas of food action or nutrition, education, and other basic needs.

In this respect, Mr. Chairman, I must note the special urgency of providing adequate external financial resources to support these actions already encouraged by the United Nations, USAID and many other bilateral agencies and a wide range of private organizations. The additional $50 million per annum which this committee has proposed would provide critical support for advancing the immunization 1990 effort. Perhaps I might also add here that any lessening of the United States regular contribution to UNICEF would be a severe blow to——

Mr. HALL. Are we getting close to the end, Dr. Jolly?

Dr. JOLLY. I'm so sorry. I have two more paragraphs.

As the economic crisis appears likely to be prolonged through the 1980's for many countries. The need to incorporate a human dimension into the adjustment effort becomes even greater. U.S. support for adjustment policies which protect the most vulnerable needs to be added to the call for more growth-oriented adjustment already emphasized by the U.S. Government. The United States, as a major bilateral donor, can play a valuable role in supporting projects as well as policies to protect vulnerable groups during adjustment. Thank you, Mr. Chairman. I apologize that I was a little long.

[The prepared statement of Dr. Jolly appears at the conclusion of the hearing, see p. 53.]

Mr. HALL. Thank you, Doctor.

Mrs. Roukema.

Mrs. ROUKEMA. Doctor, in consideration of the time, I would like to submit a question for your written response, and that is concerning the problem of the sustained delivery system. I would like to have the benefit of the experience of UNICEF and your own perspective as to how feasible this is, and what your experience has been with it, and what you foresee is the elements of necessary strategy for the future. Thank you.

Mr. HALL. Mr. Dorgan.

Mr. DORGAN. I just want to thank the doctor for his testimony. I think the kinds of things you are doing are incredibly exciting. We, you might have been told, had a caucus this morning. It was called about the Soviet threat. We described what is going on militarily around the world, and petty cash from what is being spent in those areas could do so much good in this world with the kind of programs you are talking about. Let's hope some day we can get to that point where we have full funding of immunization programs and others, and I commend you for your work.

Mr. HALL. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Dr. Jolly, I am very much impressed with your testimony and have been looking through it as you read sections of it, and I think that I personally will find some of your data extremely useful. I notice the charts in the back on the percentage of under 5's below 80 percent, the weight standard, and I notice wide variations in various parts of Africa.

I am particularly interested to note that perhaps the lowest percentage of children in difficulty as measured by that particular index seemed to be in Lesotho, and that raised in my mind the question that never seems to be discussed as to just what the condition of children is in South Africa relative to most of the other African countries and what provisions are made for feeding and health care in South Africa compared to some of the other less developed parts of Africa. Could you comment very briefly on that just for my edification here.

Dr. JOLLY. It is not an area on which I have direct expert information, but I am happy to give an informal comment, and perhaps a useful reference.

Mr. EVANS. Yes.

Dr. JOLLY. The informal comment is that from data I have seen, the country is far from without problems, although because of its overall wealth, the level of services in some respects is quite useful, but the inequality of services on a racial basis is, of course, enormous. Perhaps in my reference I could introduce at this point. There is the largest single study ever undertaken of poverty in South Africa being undertaken by a professor, Francis Wilson, with the support of the Carnegie Foundation. He will be presenting results of his study next week in New York, and he will also be publishing the first of the series of volumes on this, drawing on the work of a number of researchers, African and non-African, throughout South Africa. I think it is 400 studies in all.

I would be very happy to make available those to you.

Mr. EVANS. I would like very much to see that. That would be very useful to me. Thank you very much.

Mr. HALL. Thank you, Mr. Evans. Thank you, Doctor, for your testimony. We appreciate it very much.

Dr. JOLLY. Thank you very much. I will be pleased to provide a written report on the issue of sustainability. It is a major issue. We have some reports already on it. I hope it is an issue which the committee can continue to give attention to. Thank you.

Mr. HALL. Our next guest is Dr. Abdoul Salam Kabore. I hope I pronounced that correctly. He is the Minister of Health for Burkina Faso. In 1984, Burkina Faso conducted a national immunization campaign which is protecting 60 percent of its children against three killer diseases: yellow fever, meningitis, and measles, and the success of this campaign can serve as a model for other developing countries in Africa and around the world. Mr. Minister, thank you very much for coming, and we understand that you have a statement, and we will accept it as part of the record.

It is not necessary for you to read it, but appreciate you for taking the time to be here.

STATEMENT OF ABDOUL SALAM KABORE, M.D., MINISTER OF HEALTH, BURKINA FASO

Dr. KABORE. Thank you very much, Mr. Chairman.

Mr. Chairman, ladies and gentlemen. I am honored to be able to address you today. My first words are to extend our thanks and appreciation for inviting me to attend and participate in this forum.

I have prepared a written statement to be submitted for the record, but allow me to present a short summary of the situation in Burkina Faso and the actions we have undertaken. But first, where is Burkina Faso? My country is a little country in West Africa. Its population is about 8 million. Our neighbors are Mali, Niger, Ivory Coast, Ghana, and Togo.

The current government took power in August 1983. After coming to power, our Government decided to place health on the top of our social economic priorities. The main health problems in my country may be grouped in five categories: a high prevalence of communicable diseases which causes high rates of morbidity and mortality; nutritional deficiencies, insufficient water supply and sanitation; insufficient and poor distribution of equipment, and medical, sanitary infrastructure; lack of qualified personnel.

The results are as follows: the general mortality rate is 25.8 per 1,000; infant mortality is 182 per 1,000 live births, and life expectancy at birth is 42 years in the urban centers and only 32 years in the rural areas. In addition, Burkina Faso has only 1 medical doctor for 44,000 inhabitants; 1 pharmacist for 85,000; 1 midwife for 33,000, whereas the standards recommended by WHO are 1 medical doctor for 10,000; 1 pharmacist for 20,000; and 1 midwife for 5,000.

Faced with these numerous health problems, the Government of Burkina Faso has developed a policy which guarantees health for all by mobilizing the population. In order to reach our objective of health for all, we have committed ourselves to establish an adequate system of maternal and child care; to an immunization policy against communicable diseases through expansion of vaccination campaigns; and to a program of mass education for good hygiene.

Cognizant of the fact that sick people cannot be productive, we are committed to undertaking certain priority actions. These have already proven fruitful in the vaccination sector, where our Operation Vaccination Commando campaign achieved considerable success.

During 2 weeks this operation was able to vaccinate about 2 million children against measles, yellow fever, and cerebral spinal meningitis. The creation this year, 1986, of a primary health post in each of our 7,500 villages during the period of November 1985 to January 1986 has permitted us to make primary health care available to all the population.

Mr. Chairman, ladies and gentlemen, as you may observe from this report, the health status of my country inextricably linked to our socioeconomic situation requires a substantial and sustained effort on our part. We are confident of success in our battle to improve the health of our people, for they themselves are determined to be free from the misery and poverty which continues to afflict our nation. As no people can entrust their development to others, Burkina Faso is committed to make the necessary sacrifices, first and foremost calling on its own financial and human resources to this end.

The aid we receive from our friends, countries, or organizations like UNICEF, including good will and cooperation, will encourage us in these efforts, but no people should depend solely on others.

Ladies and gentlemen, I cannot end this statement without thanking the American people on behalf of our people. The National Council of Revolution and our Government for the honor you have bestowed on me by inviting me to participate in this forum. Thank you very much for your kind attention.

[The prepared statement of Dr. Kabore appears at the conclusion of the hearing, see p. 60.]

Mr. HALL. Thank you, Mr. Minister, for being here. We are excited about some of the things you are doing in your country relative to immunization and some of the private groups that you are working with. We just encourage you to continue in this vein and we will do our best to help you. We are fighting a similar battle here to try to produce legislation that we hope will increase aid to some of the developing nations, and we are very thankful for what you

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are doing and some of the outstanding achievements that you are showing us relative to reducing infant mortality.

Thank you very much, Mr. Minister. I was wondering if Mr. Evans had any questions.

Mr. EVANS. I just have a short one if I may, Mr. Chairman. I also want to thank you, and I was looking through your testimony with great interest as you were talking, and one of the things you didn't comment on is mentioned here that I have no knowledge and I have just sort of technical question. You mentioned the guinea worm disease and that kind of problem. I was curious as to whether that is transmitted to humans by drinking the water or just exposure to the water and the penetration is through the skin.

TRANSLATOR. Dr. Kabore would like to express himself in French, and I myself will try my best to translate.

Mr. EVANS. Well, it is not a terribly important question to me, but is it through the skin or by drinking.

Dr. KABORE. Both.

Mr. EVANS. Both. OK, that is sufficient. Thank you very much.

Mr. HALL. Thank you so much, Mr. Minister, for coming and sharing your testimony with us. We look forward to hearing about the great things that you are going to be doing in your country in the near future. Thank you.

Dr. KABORE. Thank you very much.

Mr. HALL. The last panel I would like to bring all up together. We have John Costello, the executive director of the Helen Keller International. We have Dr. Warren Berggren who is of the Save the Children Federation. We have Dean Hirsch of the World Vision Relief organization. I would ask them to take a seat in front of the three microphones.

John Costello, as I said before, is with the Helen Keller organization, and he will describe his agency's work in reducing vitamin A deficiency worldwide, particularly in Indonesia, the Philippines, and parts of Africa. Dr. Berggren will present testimony on his agency's child-survival programs in Zimbabwe, Bolivia, Ecuador, Indonesia, and Bangladesh and proposals to enhance programs in 17 countries. Mr. Hirsch will discuss his agency's child-survival activities worldwide, particularly expansion of immunization efforts in Africa.

We thank you for being here. Some of you have been here many times before. We appreciate you coming to tell us about the great things that you are doing. We would ask that you keep your testimony down to 5 minutes or under. I think we will start off with Mr. Costello and just go right down the list.

STATEMENT OF JOHN COSTELLO, EXECUTIVE DIRECTOR, HELEN KELLER INTERNATIONAL, ACCOMPANIED BY ALFRED SOMMER, M.D., DIRECTOR, DANA CENTER FOR PREVENTIVE OPHTHALMOLOGY, THE JOHNS HOPKINS MEDICAL INSTITUTION

Mr. COSTELLO. Thank you, Mr. Chairman. I would like to note that I have Dr. Alfred Sommer with me today. I realize time is short, but he did travel from Baltimore to be here this morning.

You may certainly want to have the opportunity to have him make a very brief comment.

It was almost 1 year ago today that Dr. Sommer and I appeared before this committee to speak about the importance of the child-survival initiative and to highlight the sightsaving and lifesaving qualities of vitamin A. Once again, we want to express our appreciation to you, Congressman Hall, for your personal leadership, and to your colleagues for your positive reaction to the news then that a 2-cent megadose of vitamin A delivered twice annually to malnourished children in developing countries can save 500,000 youngsters from blindness each year, and even more importantly save the lives of millions of children.

Your staff report on the significance of vitamin A issued as a result of our testimony last year has had a tremendous impact, and it has served to greatly increase the awareness and commitment to vitamin A supplementation by a number of international and national organizations, corporations, and private voluntary organizations. WHO is launching a major 10-year initiative to control vitamin A deficiency. Major American PVO's like CARE, Save the Children, and Africare, and Meals for Millions will include vitamin A supplementation and nutrition education in their child-survival activities.

UNICEF, which has long played a key role, I am pleased to say will be renewing its attention to the role of vitamin A and child health. I am particularly pleased that the private sector has initiated increased commitments as well. I would like to note that Hoffmann-La Roche, one of the major manufacturers of vitamin A, has pledged significant financial and technical resources to assist these efforts on a broad scale.

As a result of the earmark last year, Helen Keller International has been planning for several months now to launch a second wave of vitamin A supplementation that will reach an estimated 20 million children a year over the next 3 years at a projected cost of 65 cents per-child-per-year, while at the same time addressing the need for permanent solutions to widespread deficiency through nutrition education, social marketing, and food fortification.

Because of the congressional recognition last year of the significance of vitamin A for the well-being of the world's children and because Helen Keller International is the world's most experienced and operational institution for vitamin A technology and programs in developing countries, we feel a special responsibility to assume a leadership position. We have outlined to AID a program which focuses on three principal aims: One, to capitalize on our major program initiatives now underway in Bangladesh, Indonesia; to initiate new major initiatives in countries where vitamin A deficiency is particularly widespread and infant mortality rates are particularly high, and where we have a chance for success—in the Philippines, in Asia, Sudan, Mali, Burkina Faso, and Niger in Africa.

I was very interested to note the Minister of Health of Burkina Faso here. I am very happy to tell you that we will be initiating a project there without AID funding in collaboration with UNICEF and with major financing from Liveaid Bandaid. We will also be looking at Haiti in our hemisphere.

While we look at those specific country interventions in Africa, when we think about Africa, we want to really focus on the third element of our proposal to AID, and that is to rapidly increase vitamin A supplementation and nutrition education for millions of children at grave risk of malnutrition, respiratory and diarrheal disease by providing technical assistance and training to a range of institutions, particularly PVO's now involved in feeding, maternal child and health care, child survival, and in small scale agricultural initiatives. This is the approach we intended to take in Africa where we are now recording alarming rates of nutritional blindness in countries where infant mortality rates are among the highest in the world.

Given the scope of the problem and the economic and structural realities in Africa, the best hope for fast large scale, low cost impact is to pursue the integration of vitamin A activities within a wide range of existing and planned child survival and agricultural programs. That will be a major part of what our effort will be.

I am also pleased to report to you that the prime time ABC-TV news show, 20/20, has just been out in the Philippines filming the HKI/Johns Hopkins/government of the Philippines initiative in that country. Hugh Downs, who chose to report the story himself, asked me to tell you that,

> There is great personal, as well as professional, satisfaction in my being able to report from these remote villages in the Philippines of the work of Helen Keller International in meeting the crucial health needs of small children suffering from vitamin A deficiency.

I won't read his whole quote, but rather will go on to say that this committee and Congress, with regard to your instincts in pursuing the issues of child survival should be congratulated and for your instincts with regard to pursuing the earmark for vitamin A as well. The actions taken by you, Mr. Hall, and your colleagues to insure a strong nutritional component within the total child survival strategies has certainly been a life-saving force for millions of children and will continue to be so.

Beyond that, beyond the actual funds allocated—and I think this is a very important point—it has provided global visibility and momentum that is just beginning to swell, and it goes far beyond just the minor amount in global terms that was allocated as a result of congressional action. As a result of your leadership institutions around the world are indeed making increased commitments to the role of vitamin A in child survival, and I urge that this special allocation of funds be continued in the next fiscal year.

The lack of an earmark does tend to send a signal that nutrition interventions are not key to child survival strategies. ORT and immunizations, the principle emphasis of child survival interventions, cannot achieve full success without improving basic nutritional status of children, as well. Malnutrition triggers a vicious cycle. It deprives children of energy they need to grow. It weakens their immune system. It leaves them vulnerable to febrile infectious diseases that further deplete their meager energy stores and further suppress their immune systems. This cycle sends already debilitated children further along on the road to death.

The role of vitamin A in this dreadful scenario of malnutrition is becoming increasingly recognized. An adequate diet of vitamin A is

critical to insure a child's resistance to the respiratory and diarrheal diseases that, though they are trivial in our country, kill children in the Third World.

I would end by just pointing out that Hugh Downs, as a result of his visit to the Philippines, calls vitamin A the health story of the year, and we will look forward to seeing that being broadcast in mid-June to a population of some 25 million people. Thank you very much, Mr. Chairman, again, for your support.

[The prepared statements of Mr. Costello and Dr. Sommer appear at the conclusion of the hearing, see p. 64 and p. 67.]

Mr. HALL. Thank you very much.

Mr. Berggren.

STATEMENT OF WARREN BERGGREN, M.D., SAVE THE CHILDREN FEDERATION

Dr. BERGGREN. For the record, I am Warren Berggren. I am a physician, and I am director of Primary Health Care for Save The Children. The testimony that I have has to do with my practice and research which concerns helping families use their own resources to protect their children and with helping them make effective use of the health services provided by their governments. These are a couple of important items for the sustainability of the efforts that are being funded.

I have given you several pages of written testimony, and I will just read a few sections of it so that we close on time here.

Save the Children promotes development by training families and communities in skills that promote self-reliance to earn a living, improve their quality of life and protect their children. Training to protect children must focus on what is most likely to kill or disable a child in its particular community of residence. Parents and community institutions can then be taught the specific skills that will prevent deaths or disabilities.

They can also learn to motivate each other to practice these child protective skills appropriately. Care for diarrhea is an example. Families can learn to use household materials to prevent diarrhea from leading to dehydration and finally to death. When whole neighborhoods learn this skill as a group, they can encourage each other to practice it correctly and in timely manner.

Of course there are other skills which require the intervention of the whole community and of governments and certainly vaccination is one of those, but the maintenance of this very important health measure really depends upon the motivation of families and communities to maintain this as an important skill or help to prevent their children from dying or being disabled.

Finally, something was said this morning about mothers, and I think that that deserves some emphasis. If mothers are absent, ill or dead, their children run enormous risks of death and disability; so mother's health is essential for child health. In some cases this relationship is extremely direct. For example, in some rural areas the only certain way to prevent tetanus of new-born infants is to vaccinate women against tetanus long before they deliver their babies. The antibodies produced by the mother pass through the placenta and passively immunize the child before birth. Protecting

mothers is approached in the same manner as protecting children. This, as relevant skills are identified, families are trained to practice them and the community institutions are trained to support the family in their practice of these skills.

I want to say just briefly what we are doing with the funds that were granted to us last year and what we could do with more. During the past 4 months we have recruited and trained the national personnel in each of our five countries that are supported with these child survival funds. We have also acquired most of the materials and equipment. Acquiring equipment has been a major problem because U.S.-built vehicles are not available in some of our countries and as of today, we have still not received from AID the waiver which will permit us to buy the vehicles that are available in the countries in which we work.

This difficulty is being overcome by some measures to borrow and rent vehicles, but it is a major break to keeping our commitments to ministries of health and to the communities in which we work. We do have considerable experience and can show that these simple interventions are very effective in saving lives in countries such as Bangladesh, Ethiopia and others.

We recognize that serving only 1.3 million people meets a very tiny fraction of the world's need for primary health care. All the enormous figures we have heard this morning are very impressive, but we want to insist that our assistance is meaningful, not only to those beneficiaries, but also to their compatriots. In every country we plan and work closely with ministries of health. We employ young professionals from the nations in which we work, and we engage them in the solution of the important national health problems. Our model for health care is original and has potential to permit rapid expansion of cost-effective health care to large populations.

National adaptations of this model and the skills acquired by young national professionals, therefore, are likely to benefit many more than the presently targeted beneficiaries.

In conclusion, I want to say something that might go for all of the private voluntary organizations that applied for child survival funds. We are all indeed grateful for this opportunity to do more than we have already done in the past to save lives and health of children. In return, however, your constituencies who are providing the challenge grant money are getting a fantastic bargain. All of us private voluntary organizations have pledged to implement, at the grass roots level, health technology of proven capacity to change the rates of mortality and disability among children.

We have also pledged to report our results in terms of lives saved. We have accepted the reporting system instituted by USAID which will assure that our impact on child survival will be measured. The reporting system is so rigorous that only a few researchers, myself among them, have experience in making it work in the past. We are not research organizations but we accept this challenge because we want this opportunity of survival for children.

We realize that other organizations and agencies have received the lion's share of these funds, and we hope that they, too, will be giving you as good a bargain as the private voluntary agencies are. Perhaps the research, technical assistance, consultation, bilateral

aid will have as a great an impact on child survival as the private voluntary organizations grass roots level projects. We would have liked to have heard reports on that today. That might have changed our way of working.

Surely we believe that you, Mr. Chairman and members of the committee, would like to know what that impact might be since it concerns a good deal of money which you have worked very hard to reserve for a very important purpose.

[The prepared statement of Dr. Berggren appears at the conclusion of the hearing, see p. 69.]

Mr. HALL. Thank you, sir.

Dean Hirsch of World Vision.

STATEMENT OF DEAN HIRSCH, DIRECTOR, WORLD VISION RELIEF ORGANIZATION

Mr. HIRSCH. Thank you, Mr. Chairman. My name is Dean Hirsch, and I serve as director for the World Vision Relief Organization, and I have submitted to the committee a copy of my testimony, so I will just——

Mr. HALL. Without objection, all of your reports, of course, and statements will be part of the record.

Mr. HIRSCH. World Relief Organization is one element of an international partnership. We seek to acquire U.S. Government assistance in such areas as food assistance through Public Law 480 and section 416 grants for emergency relief assistance throughout the sub-Sahel, Africa, and matching funds for developmental programs in Africa and Asia, as well as utilization of the Child Survival Program funds.

Our largest child survival program to date is the Mashonaland East project in Zimbabwe. This project has been made possible through a child survival fund grant provided in partnership with USAID. This grant was awarded in June of 1985, and by the conclusion of the project's 3-year duration, an estimated 75,000 people will have benefited. Zimbabwe's child survival project is critical not only to those it serves, but also as a prototype in World Vision's efforts to implement our commitment to child survival.

World Vision is strongly committed to participation in the worldwide movement to immunize all children by 1990, and as a response to this commitment has been actively pursuing the development of a new and expanded organizational health strategy. This strategy has recently included the request to USAID for funding of three additional child survival projects in Kenya, Sudan, and Senegal, which would serve a total population of approximately 320,000 people. In addition, the 400,000 children in World Vision's child care project communities will be immunized by local health authorities in the next 3 years. World Vision is also organizing large immunization campaigns with special private funding from individual donors in the United States and Canada.

We have adjusted our internal structure to better facilitate and coordinate our child survival and immunization programs. Our long-term goal is to further increase our management capacity with appointments of additional facilitators in each of our country's field offices. World Vision sees a critical relationship between

relief programs and the child immunization in providing a threshold to broader development impacts. Starting with the release of health problems, an organization can build upon community trust and a trained volunteer network to progress into meeting other basic needs for self-reliance within the community.

However, none of these goals can be met without the continued and increased cooperation with sister agencies, UNICEF and the host country ministry of health. Moreover, they will not be accomplished without a continued commitment on the part of Congress and USAID to partner with the contributions of individual citizens to private voluntary organizations. World Vision highly commends Congress and USAID for the increased availability of funding for child survival programs and wholeheartedly supports the increased funding for the child immunization currently being considered in H.R. 3894, the Universal Child Immunization Act.

Particularly in this critical time of budget considerations under the Gramm-Rudman legislation, the commitment to child survival and immunization funding must be maintained. While we realize the considered need for difficult budget decisions, we must hope for continued child survival and immunization funding in the face of even greater needs and more limited resources in the developing world.

In summary, Mr. Chairman, World Vision supports the current and future child survival initiatives of Congress, as well as the proposed Universal Child Immunization Act. World Vision is implementing successful health and child survival programs in nearly 50 countries, both through private funding and USAID matching contributions. These programs are benefiting nearly 1.4 million individual lives. We are committed to continue these programs and are prepared to expand them, if the Congress and the American public continue to support the expression of legitimate concerns in such tangible ways.

While a number of additional colleagues in sister agencies could have shared their own experiences and thoughts with you today, I believe it is safe to say that I speak on behalf of all PVO's in emphasizing that we are prepared to participate in even greater ways if funds continue to be made available. The tragedy is that the cost to us now is only a few dollars per child to save the estimated 4 million children who die each year from six immunizable diseases, and the additional 5 million who are permanently and needlessly disabled. We have a window of opportunity before us, with a growing public support, international commitment and political will behind us. To do less than all that we now can is to forsake the hope of current and future generations.

Finally, in January 1986 World Vision and 15 other private voluntary organizations engaged in the delivery of primary health care at the grass roots level joined together under the mandate of the Development Assistance Committee of Interaction, a coalition of more than 100 private and voluntary organizations working in international development, to form a task force on child survival and development. The task force exists to enhance effective delivery of child survival and development programs through the promotion of the discussion of critical child survival and developmen-

tal issues, member coordination and ongoing evaluation and analysis of current child survival initiatives.

Interaction's task force has been instrumental in articulating the concerns of those agencies involved in the delivery of child survival programs. In addition, Interaction and the U.S. Committee for UNICEF have launched a major campaign for child survival to educate the American public on this critical issue. On behalf of the task force, I would like to request the opportunity to submit recommendations in writing for consideration by the committee for strengthening the current child survival program, recommendations made in the spirit of our shared commitment for improving the lives of children and their families worldwide. Thank you.

[The prepared statement of Mr. Hirsch appears at the conclusion of the hearing, see p. 72.]

Mr. HALL. Thank you, Mr. Hirsch.

Mr. Costello, thank you again for coming before the committee and especially for the great work that Helen Keller International is doing in the field, especially in informing Members of Congress of vitamin A. It has been a real education process, and from what we have seen, at least through your report of the action in Indonesia, we look forward to the other reports that are apparently coming out in the very near future.

I would like to ask one question. If more funding became available this year through the budget, what kind of programs would you expand in? What countries would you go into?

Mr. COSTELLO. Well, the program that I outlined to you, Mr. Chairman, looks at a major program focus and expansion in Africa, and as we speak now, we have not received any of the funds that were earmarked in last year's congressional actions so that there is tremendous room for major expansion. We are looking at four to five individual initiatives in Africa, along with major program expansions on the part of other PVO's—Save the Children, CARE, Africare—that have been indicating very strong interest, so it is very difficult for me to somehow answer that, but that there would be a major program expansion certainly on just what we have proposed and what was submitted to AID last week on the 24th.

Mr. HALL. You haven't received your money yet, but you have planned in Africa, mainly, where you would spend your money.

Mr. COSTELLO. Well, we have submitted a proposal that looks at a 3-year global effort, as I said, looking at capitalizing on the major program initiatives that are underway in the Philippines, Bangladesh, and Indonesia, and it is really taking those projects to national scale and achieving lasting and dramatic reductions in widespread vitamin A deficiency that exists in those countries.

The Africa initiative looks at specific country interventions in Sudan, Mali, and Niger with this technical assistance approach, and then an approach to provide technical assistance in Nepal and in Haiti where it is a tremendous problem and exists today. Now that is an effort that looks at, as far as the aid request, at some $7.3 million over a 3-year period. Now, there are other sorts of things that need to be conducted.

Mr. McPherson, this morning, mentioned the research that needs to be continued as a result of the very dramatic findings of the research in Indonesia. Now, those are planned in collaboration with

Johns Hopkins and possibly Cornell University to take place in Bangladesh and the Philippines. Philippines is a very critical priority. Those are not included in that request.

From what we know about the needs, they far exceed the resources, in terms of the initial $8 million that was earmarked last year. I know just in the collaborative efforts that we have looked at with regard to those institutions that are involved both in programs and in research, we have clearly identified in the very short term the need for 17 to 18 million dollars' worth of resources, and that does not include the resources that other institutions could program with regard to their initiatives in Africa and elsewhere.

Mr. HALL. Dr. Berggren, as you know, this committee supports very much your child survival program. We also understand that you would like Save the Children to expand this program into 17 countries. Can you describe briefly some of those programs that you want to initiate?

Dr. BERGGREN. Yes, all of the proposals are very similar in that they are developed to teach and train parents and communities to make the best use of their resources to protect the health of their children. They have very specific educational objectives. They need to be supported by government sometimes and by private sources. But we feel that they are sustainable in that they train people to take care of their children.

We think that these are based on a good scientific basis. We have 17 years of followup on a similar program that I directed in Haiti, and know that these behaviors, these skills can persist and can continue to be saving lives long after they have been taught. Of course, it does need the continued input of things like vaccines, like organizations, government, and so forth that can get the vaccine to an appropriate place and administer it appropriately.

There are a lot of things that communities and families can do for themselves like learn how to do oral rehydration based on household materials. All of these—I could go through a list of 10 of them which we think are important, but 4 of them, at least, are covered by USAID's guidelines.

Mr. HALL. Thank you, Doctor.

Mr. Hirsch, as you know, I traveled in January and became personally acquainted with some of the immunization programs that World Vision is doing in Ghana and Mali, specifically. I saw them being carried out, and I was delighted in some of the things I was seeing, and I thought it was an excellent program. I would like to ask you if moneys became available for global immunization—more moneys than last year, where would you expand your activities?

Mr. HIRSCH. If moneys became available as well as the second factor of aid would increase the list of 10 countries that are eligible for the survival funds. We would be able to take that money and expand into countries like Zambia and some countries in West Africa and some of the countries down in the southern Africa region, as well as in Latin America. Only two are eligible now to receive funding in Latin America, so we definitely are prepared to expand if funds were available and the list was broader to move into some of the 50 countries where we are taking the key elements of the child survival program and implementing in our existing programs.

Mr. HALL. That was one of the questions that I wanted to ask Mr. McPherson about increasing that list of countries, but it is on a list of questions that we will be sending him——

Mr. HIRSCH. That would be most helpful, Mr. Chairman.

Mr. HALL [continuing]. Pushing him as the administration or as an agency to help qualify some of those other countries.

Well, thank you all for the wonderful work that you are doing. We are very appreciative of your testimony, your statements, your support toward many of things that we are doing in Congress. We, of course, support you.

[Whereupon at 12:30 p.m., the subcommittee was adjourned subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

MR. CHAIRMAN:

SINCE ITS INCEPTION IN 1984, THE INTERNATIONAL TASK FORCE OF THE SELECT COMMITTEE ON HUNGER HAS STUDIED AND INVESTIGATED THE PROBLEMS OF MALNUTRITION IN THE DEVELOPING WORLD. ONE LOOK IN THE EYES OF A SICK AND STARVING CHILD FROM AFRICA, ASIA OR LATIN AMERICA MAKES IT ABUNDANTLY CLEAR THAT OUR EFFORTS ARE NEEDED AND THAT CONTINUED EMPHASIS MUST BE PLACED ON HEALTH AND NUTRITION FUNDING IN OUR FOREIGN ASSISTANCE PROGRAM. IN 1985, CONGRESS APPROVED THE CHILD SURVIVAL FUND IN ORDER TO AID THE MOST HELPLESS VICTIMS OF HUNGER AND DISEASE - CHILDREN.

DURING MY SERVICE ON THIS COMMITTEE, I HAVE COME TO REALIZE THE PERNICIOUS LINK BETWEEN MALNUTRITION AND THE MALADIES WHICH AFFLICT SO MANY CHILDREN IN LESS DEVELOPED NATIONS. FOR INSTANCE, 3 OF EVERY 100 CHILDREN DIE FROM THE EFFECTS OF MEASLES IN DEVELOPING COUNTRIES. A COMBINATION OF WEAKENED RESISTANCE DUE TO MALNUTRITION AND A LACK OF ADEQUATE IMMUNIZATION LEADS TO THE NEEDLESS DEATH OF MILLIONS OF CHILDREN EACH YEAR FROM THIS DISEASE ALONE.

IN MY OPINION, THE FOCUS OF THE COMMITTEE ON EFFORTS TO ENHANCE HEALTH PROGRAMS FOR CHILDREN HAS BEEN ONE OF ITS MOST IMPORTANT TASKS. LAST YEAR WE HEARD TESTIMONY THAT 11,000 CHILDREN A DAY DIE FROM SIX INFECTIOUS DISEASES. IF THIS NUMBER OF FATALITIES RESULTED FROM A NATURAL DISASTER, THEN AN IMMEDIATE INTERNATIONAL RELIEF EFFORT WOULD BE INSTITUTED. WHAT MAKES THIS ASTONISHING NUMBER SO ABHORRENT AND INSIDIOUSLY TRAGIC, IS THE REALIZATION THAT WE HAVE VACCINES WHICH CAN PREVENT EVERY ONE OF THESE DEATHS. WHAT WE LACK ARE EFFECTIVE NATIONAL PROGRAMS OF IMMUNIZATION IN THE DEVELOPING WORLD.

THE COSTS OF IMMUNIZING A CHILD ARE SMALL WHEN YOU CONSIDER THAT THE RESULTS PAY HUGE DIVIDENDS IN TERMS OF REDUCED FUTURE HEALTH-CARE COSTS, REDUCED INFANT MORTALITY AND HEALTHIER CHILDREN. HIGH LEVEL POLITICAL SUPPORT IS ESSENTIAL IF WE ARE TO MAKE PROGRESS IN IMMUNIZING ALL THE WORLD'S CHILDREN. IF OTHER COUNTRIES, INTERNATIONAL ORGANIZATIONS AND PRIVATE

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VOLUNTARY ORGANIZATIONS MAINTAIN A COMMITMENT TO WORK WITH THE UNITED STATES, WE CAN SAVE THESE CHILDREN.

I HAVE JOINED MY COLLEAGUES ON THE HUNGER COMMITTEE IN COSPONSORING A MEASURE WHICH WOULD INCREASE THE RESOURCES AVAILABLE TO ESTABLISH AND AUGMENT NATIONAL IMMUNIZATION PROGRAMS. I KNOW THAT BOTH THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND UNICEF HAVE TAKEN THE LEADERSHIP IN PURSUING WORLDWIDE CHILDHOOD IMMUNIZATION, AND I LOOK FORWARD TO TESTIMONY FROM MR. MCPHERSON AND DR. JOLLY DESCRIBING THEIR EFFORTS.

THE COMMITTEE HAS ALSO SOUGHT ACTION TO STOP THE BLINDNESS AND DEATHS THAT HUNDREDS OF THOUSANDS OF CHILDREN FACE EACH YEAR BECAUSE THEY LACK VITAMIN A. REPRESENTATIVES OF THE PRIVATE VOLUNTARY ORGANIZATIONS JOINING US TODAY CAN TELL US MORE ABOUT EFFORTS IN THIS AREA SPECIFICALLY AND ABOUT THEIR MORE COMPREHENSIVE CHILD-HEALTH PROGRAMS.

I HOPE THIS HEARING WILL POINT OUT TO ALL THE IMPORTANCE OF EFFECTIVE HEALTH-CARE STRATEGIES IN THE DEVELOPING WORLD AND THE CONTINUING NEED FOR PRIVATE AND PUBLIC ASSISTANCE FROM WESTERN DONORS, DESPITE THE SEVERE BUDGET CONSTRAINTS WE NOW FACE. IF WE SEEK TO COORDINATE ALL OUR EFFORTS, THEN WE CAN GO A LONG WAY TOWARD ACHIEVING A SUSTAINABLE PROGRAM TO PROMOTE THE GOOD HEALTH OF ALL THE WORLD'S PEOPLE, ESPECIALLY ITS CHILDREN.

PREPARED STATEMENT OF M. PETER MCPHERSON, ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

Good morning. I am pleased to appear before this Select Committee to report on the current status of A.I.D.'s Child Survival Program. This Committee has provided important leadership to the issue of child survival and I want to begin by acknowledging this critical contribution.

In a few short years, child survival has become one of the Agency's highest priorities --- indeed, a national priority. Tragic accounts of children dying, from Africa to Bangladesh, have made the dimensions of the problem all too apparent. Unbelievable as it may seem, 40,000 children are dying each and every day in the developing world. A.I.D.'s goal is to help bring down the infant mortality rate in developing countries to 75 by the year 2000, a 25 percent decline, but still nearly eight times the rate in the U.S. We have similarly ambitious goals for extending services to reduce disease and disability.

We have learned a great deal about how to prevent much of this suffering. The report we submitted to Congress last December on our FY 85 program documented some of our successes. I have seen the miracle of a small child snatched from death by means of oral rehydration, a simple therapy of sugar, salts and water given by the teaspoonful over several hours. It is harder to see a death prevented by immunization against measles, whooping cough and other common childhood diseases, but we know that 3.5 million lives a year could be saved if immunizations that Americans take for granted were universally available. Our goals in concert with other agencies and donors are to prevent two million deaths through the use of ORT in 1990 and to develop a sustained capacity to immunize the world's children.

Turning these goals into reality will require tremendous effort -- the efforts of hundreds of millions of people in the developed and developing countries as well as their leaders, and the efforts of international agencies, both public and private. It will require a sustained commitment of energy and resources.

A.I.D. intends to provide critical support. We plan to redouble our efforts to involve other leaders and other donors in this cause, through policy dialogue in the countries where we work and through international forums such as the Development Assistance Committee. A.I.D. is also committed to maintaining our role as the leading donor in assistance for Child Survival.

I have recently approved a Child Survival Strategy which I would like to insert into the record. The Strategy lays out priorities for the next five years. ORT and immunization are the "twin engines" driving our approach. These two interventions--the one treating the most dangerous consequence of diarrheal infection, the other preventing potentially deadly illness from arising--can actually lower rates of death and disease among children. They are also the foundation on which countries can build sustainable health systems capable of delivering other critical interventions such as birth spacing and nutrition.

Many of you are familiar with the remarkable results that have been achieved by A.I.D.-supported programs developing and delivering these technologies. This year, we are planning to commit more than 100 million dollars to these two technologies alone. We will maintain similar levels next year and beyond. No other donor comes close to this level of effort; the U.S. can be proud of its leadership.

The Agency also supports nutrition and other interventions that are critically important for child survival. We are seeking innovative ways to link PL 480 resources to our child survival goals so that these commodities can have a greater impact.

We estimate that 3 million lives could be saved each year if every infant had the best start -- specifically with a two year interval before their next sibling was born. A.I.D. is continuing its efforts in support of family planning programs which permit women voluntarily to space their children.

I want to emphasize that this Child Survival Strategy emphasizing ORT, immunization, birth spacing and nutrition is an Agency strategy cutting across several of our functional account sectors. There is a tendency to look at A.I.D.'s effort in terms of the size of our Child Survival Fund or our Health Account. This does not present a full or fair picture of the extent of this Agency's commitment. In addition to the Population, Health and Child Survival accounts, the ESF, Sahel, Agriculture and PL 480 programs contribute importantly to our total child survival effort. In FY 1986, we estimate that our child survival program from all accounts (exclusive of Population and PL 480) amounts to nearly $160 million dollars. In FY 87, our request has declined in light of overall budgetary stringencies. Nonetheless, by concentrating more fully on child survival priorities, we expect to provide at least another $125 million dollars, again exclusive of population and PL 480 funds. This makes A.I.D. the leading funder of child survival activities, and I am committed to sustaining this leadership role.

I am equally determined to insure that the technical staff resources are available and in place to support this role. I know of the concern of this Committee and other Committees for the size of our current health professional staff. While I am determined to maintain both the size and quality of that staff, in the current budget environment it may not be practical to anticipate meaningful increases. Given this reality, the Agency has moved with determination and, I believe, creativity to obtain the professional technical support that is needed from private contractors and other sources. For example, our immunization programs in Africa are supported through an agreement with the Centers for Disease Control which provides 22 experts to strengthen child survival efforts on that continent.

A.I.D. is currently supporting ORT, immunization and related activities in more than 50 countries. We need to concentrate our efforts where the problems are greatest and where we can make the largest difference. Starting this year, we are placing special emphasis on 22 of those countries where child survival problems are especially severe and where A.I.D. can maximize its impact. These countries account for about two thirds of all infant deaths in the world.

In these "emphasis countries," A.I.D.'s" commitment includes:

(1) sustained bilateral funding for country-specific child survival activities for at least the next three to five years;

(2) a coordinated approach involving support for U.S. and indigenous private voluntary organizations, international organizations such as WHO and UNICEF, and other U.S. agencies such as the Peace Corps; and

(3) priority backup from A.I.D. in Washington.

Our programs seek to capitalize on A.I.D.'s comparative advantage with regard to the private sector, particularly our many excellent private voluntary organizations and the growing number of such groups in developing countries themselves.

In FY 85, A.I.D. provided more than $30 million to child survival activities of private voluntary organizations. Three channels were used - grants to U.S. and indigenous PVOs by USAID missions as part of their bilateral programs; a major grant to UNICEF for support of indigenous PVOs, and, largest of all, a $13.5 million program of grants to U.S. PVOs awarded on the basis of competitive proposals. Some of those A.I.D.-supported PVOs are here today, to tell you of their activities.

This year approximately thirteen million dollars of the additional Child Survival Funds are being devoted to PVO activities, including a continuation of the PVO competitive grants program, this year focused primarily on Africa.

A.I.D.'s pioneering work in the area of social marketing is now being recognized by the world health community as a vital contribution to expanding health education and stimulating demand for services. Since the effectiveness of many of the child survival technologies depends on their use by ordinary people rather than the traditional health establishment, it is particularly important that all avenues of communication be brought to bear, from the traditional village midwife to TV and radio networks. A.I.D.'s social marketing initiatives have demonstrated the value of modern communications strategies, particularly when they are combined with person-to-person activities. Careful planning is particularly important, so that manpower, supplies, and popular demand all grow at roughly the same rate. Increasingly, these strategies are features of all major child survival programs.

We are also very much aware that child survival programs may be hard to sustain after the first bursts of enthusiasm. Several ingredients are essential to sustainability.

The political leadership must be committed to supporting these programs over the long haul and developing a base of popular support for them. When Ecuador's First Lady took the lead, for example, that country's immunization campaign took off. Churches, businesses, schools, radio and TV as well as government ministries, all joined in. One of our technicians has just come back and she reports that Ecuador's child survival program - which also includes ORT and growth monitoring - is "Remarkable. They have done two year's worth of work in less than one."

Second, governments must make the hard budgetary decisions that will allocate scarce resources to sustain these programs on an ongoing basis. An allocation of scarce resources to preventive programs such as immunization does mean budgetary saving in the long run. Even when governments recognize this, it is nonetheless difficult to find additional resources or move them away from other programs.

Third, health systems must be able to deliver services throughout the country, not just in the big cities. In countries where a health infrastructure already exists, A.I.D. focuses assistance on introducing or strengthening the ORT and immunization components and on developing retail sales activities through the private sector. In countries without an effective infrastructure, we need to pay more attention to developing one, and this means managerial and professional technical assistance, training and other support for public and private health systems.

Immediate needs are so important it is tempting to invest all our energies and resources in the health technologies we already have in hand. But without research and development of new technologies, we will not be able to meet the life-saving needs of the future. Indeed, some existing problems -- such as the resurgence of malaria in many parts of the world -- cannot be tackled with the technologies now available. Therefore, A.I.D. is committed to an aggressive, results-oriented research program to support our child survival initiatives. We have invested heavily in research on new and improved vaccines for several common diseases that affect children, on improved ORT formulas, on communications techniques to heighten awareness and demand for child survival programs and on cost-effective, efficient approaches to service delivery.

Nutrition is a critical component of child survival. As you know, A.I.D. is a major supplier of nutritionally enriched food to the developing world. A focused nutrition program promoting breastfeeding, appropriate weaning practices, growth monitoring and dietary management of diarrheal disease is an important element of our child survival strategy. With Agriculture account funds this year, we will increase the delivery of Vitamin A in areas where there are serious vitamin deficiencies. We are also allocating a portion of these funds to test the connection between Vitamin A and death and disease among children. The scientific findings of the first Indonesian study are to be published shortly. If these results are upheld, the Agency will want to incorporate Vitamin A more fully into its child survival program.

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Finally, I want to emphasize the international character of this child survival effort. WHO, UNICEF and other members of the UN community, as well as other bilateral donors and countless private agencies -- both non profit as well as commercial -- contribute importantly to the child survival effort. With UNICEF and WHO in particular, close relationships have been established. We meet frequently to go over our programs, resolve our problems, and insure effective cooperation and coordination. In January A.I.D. sponsored a meeting in Washington of this group. I am traveling to New York tomorrow for a comparable meeting sponsored by UNICEF. This coordination is critical to success. As we work together in the developing countries, we must work within the framework of one country program and one country strategy. Pulling in different directions, emphasizing different priorities, albeit under the common heading of child survival, dissipates our resources and the extraordinarily valuable managerial skills and political will of the countries we are trying to help. A.I.D. is committed to insuring that this cooperative effort succeeds.

With the provision of funding by Congress and the support of this Committee, we have built an exciting and effective program. It is saving the lives of children and improving their prospects for a full and productive life.

It is a program that is complemented by this Agency's other development efforts. Good health is more than the absence of disease and death. Self-sustaining health programs require an adequate economic base. Healthy lives require an adequate food supply which, in turn, depends on the agricultural base of a country.

The American people clearly support our commitment judging from the letters and visits and the generous response of individual citizens to private fund raising for children in the third world. Just this spring a group of organizations launched a Campaign for Child Survival in five U.S. cities. Next year, they plan to expand this campaign nationwide. It is important that this country recognize this humanitarian need and the contribution its citizens can make to an improved future for the world's children. I see this as an ideal opportunity to broaden the American people's understanding of this important development issue. A.I.D. has pledged to support that campaign under the provisions of the Biden-Pell amendment.

We agree with this Committee that 15 million needless child deaths a year are unacceptable. A.I.D. is determined to help solve this problem.

END

April 1, 1986

THE A.I.D. CHILD SURVIVAL STRATEGY

TO THE STAFF OF THE AGENCY FOR INTERNATIONAL DEVELOPMENT:

I have, several times in the last year, underlined the importance I attach to the Agency's Child Survival Programs. At my request, The Child Survival Task Force has developed and I have approved the following strategy as guidance to field missions. I call upon each mission to use this strategy as a basis for sharpening the focus of our health and related programs and as a basis for accomplishing the goals that the Agency has set to reduce the preventable deaths of children.

M. Peter McPherson
Administrator
Agency for International Development

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A.I.D. CHILD SURVIVAL STRATEGY

INTRODUCTION

Fifteen million children under age 5 die each year in developing countries. The deaths of these children account for more than half of all deaths in developing countries. In this environment, malnutrition, disease, unsanitary conditions, closely spaced births and lack of maternal education all interact in a vicious circle. Two key technologies, oral rehydration therapy (ORT) and immunization, can break into the circle and significantly reduce infant and child death and disability associated with these factors and help build a sustainable health delivery system. Up to half of the deaths in children, or one quarter of all deaths in the developing world, could be prevented by these interventions. They are the "twin engines" of this strategy.

The magnitude of child mortality and the fact that we have proven, effective interventions--ORT and immunization--which can help save half of these children are the bases for making child survival the focus of A.I.D.'s health program.

A.I.D. has joined other donors in a worldwide effort to achieve certain targets in child survival by the end of the decade. The aim is to prevent two million deaths through the use of ORT, and to collaborate in all international efforts to provide continuing immunizations for all the world's children. The Agency's Blueprint for Development also includes among its goals the reduction of infant mortality to less than 75/1000 and the reduction of mortality in children under five to less than 10/1000.

A.I.D.'s focus will be on developing a sustained capacity in each country to effectively provide ORT, immunizations and other important child survival interventions in nutrition and birth spacing to their vulnerable populations.

A.I.D. has been funding activities aimed at child survival for a number of years. In FY 1985, additional funds appropriated by Congress for child survival and related health programs allowed A.I.D. to accelerate its efforts to improve the health of children in A.I.D.-assisted countries. In FY 1986 Congress again appropriated additional funds for child survival. For FY 1987 A.I.D. is requesting a separate Child Survival Account. Funding for child survival will also come from many other accounts including Health, Population, ESF, Agriculture, Sahel, and PL 480. In future years funding will continue to come from a variety of agency accounts reflecting the multi-disciplinary requirements of this strategy.

This strategy establishes the improvement in the health and survival of children and mothers as the priority goal of the Agency's health program.

A.I.D.'S FIVE YEAR CHILD SURVIVAL STRATEGY

A.I.D.'s Child Survival Strategy seems to reduce significantly the number of child deaths in LDC'S by the end of the decade. ORT and immunization are the twin instruments for achieving this goal. These two interventions will be used as the base upon which to build effective health care systems. All designated emphasis countries should have nationwide ORT and immunization programs (drawing on A.I.D. and/or other support as appropriate).

Although ORT and immunization are the primary interventions upon which we plan to focus, birth spacing and a focused nutrition package emphasizing breastfeeding, improved weaning practices, and growth monitoring are also critical to child survival. They are an integral part of our child survival strategy.

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The two above paragraphs describe the focus of A.I.D.'s Child Survival Strategy. Within the Agency's health program, child survival will have priority. However, it is recognized that in some circumstances, other health interventions could be critical to achieving child survival goals or to address other important health needs. The case will have to be made on an individual basis that, within a particular country context or setting, they are more appropriate than the child survival activities described above.

THE IMPLEMENTATION OF A.I.D.'S STRATEGY FOR CHILD SURVIVAL INCLUDES THE FOLLOWING ELEMENTS

- Focus on ORT and immunization as "Twin Engines;"
- Support for (and coordination with) other important child survival interventions such as nutrition and birth spacing;
- Support for a results-oriented research program related to child survival;
- Special efforts focused on a limited number of "emphasis countries;" and,
- Involvement of the private sector.

SELECTIVE INTERVENTION APPROACH

The decision to focus on ORT and immunizations is based on the direct impact that these interventions can have on child survival and the capacity of these two "engines" to drive the development of a sustainable health system capable of meeting the health needs of the vulnerable populations.

IMMUNIZATION

Detailed guidance on the design of immunization activities is incorporated in the Agency's Immunization Strategy (January 1986).

The Immunization Strategy has six principal elements:

1. A primary target group of children under one year of age;
2. Emphasis on vaccines, to meet the needs of children and fertile-aged women, especially measles and tetanus-toxoid;
3. Development of county-specific plans, coordinated with other donors;
4. Major focus on target countries so as to maximize health benefits that can be obtained with available resources;
5. Emphasis on institutional capacity development to sustain host country immunization service delivery;
6. Continued research on vaccine development, immunization technology improvements, and health service delivery.

CONTROL OF DIARRHEAL DISEASE - ORAL REHYDRATION THERAPY:

Oral rehydration therapy (ORT) programs within the context of overall diarrheal disease control have eight principal elements:

1. Emphasis on support for coherent and comprehensive national ORT programs in coordination with other donors.

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2 Appropriate nutrition interventions in addition to fluid therapy, especially dietary management of diarrhea (breastfeeding, feeding during episodes, refeeding) and appropriate hygiene interventions, especially sanitation education.

3. In concert with expanded services, use of comprehensive approaches to communication, including mass media, to promote and sustain the correct use of ORT and improved feeding and hygiene practices.

4. Provision for appropriate training, including physician training, as well as adequate supplies of salts within the overall national program.

5. Support for the World Health Organization formula for oral rehydration salts and for an appropriate combination of home-mix and packet-based programs, recognizing that there are community-specific factors that require adaptation to local conditions and resources.

6. Involvement of the private sector to prescribe, distribute, and promote ORT and to produce the packets.

7. Efforts to build and finance a sustained capacity to deliver ORT and other child survival services.

8. Research on improved formulae, vaccine development, communication techniques and service delivery.

NUTRITION

In the nutrition area, the interventions most closely related to child survival include:

1. Promotion of exclusive breastfeeding to 4-6 months to reduce the probability of infectious diseases, diarrheas and associated weight loss.

2. Promotion of proper weaning practices including the introduction of solid foods between 4 to 6 months, with continuation of breastfeeding.

3. Feeding during diarrhea to prevent serious weight loss and increased feeding after episodes of diarrhea and other infectious diseases.

4. Growth monitoring to detect growth faltering and to serve as a catalyst for prescribing appropriate followup interventions, i.e. ORT, feeding, etc., in a timely fashion.

5. Vitamin A supplementation where appropriate.

6. Targeted supplementary feeding programs to children under three years old and pregnant women under PL 480 Title II where there is serious risk of malnutrition.

BIRTH SPACING

In the area of birth spacing, the interventions most closely related to child survival include:

1. Promotion of appropriate breastfeeding.

2. Provision of a full range of voluntary family planning services and supportive activities as articulated in the Agency's Family Planning Strategy.

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ACHIEVING MAXIMUM IMPACT AND SUSTAINABLE PROGRAMS

There are three important aspects of A.I.D.'s Child Survival Strategy which are critical to achieving maximum impact and long term sustainability. They are: institutionalization of services, use of modern communication strategies, and collaboration among donors.

INSTITUTIONALIZATION OF SERVICES: Sustained host government commitment is perhaps the most important part of a successful child survival program. The institutionalization of ORT and immunization services within developing countries depends upon their technical, financial and institutional viability. All three are critical to the sustained impact and effectiveness of these interventions. The importance of child survival activities and the need for institutionalization of these efforts should be part of all A.I.D. policy dialogue. All A.I.D. child survival programs must seek to develop local capacity to sustain the provision of services. This may require discussions with host countries on the reallocation and mobilization of health care resources. In all new child survival initiatives, careful analysis and planning for recurrent costs should be incorporated in the project design. Where the institutional and financial capacity to sustain these programs is weak, time-limited donor assistance for recurrent costs may be considered.

Although one-time mobilization campaigns may be critical to create public awareness and stimulate a demand for these services, the existence of an indigenous capacity to manage and deliver such services is essential to ensure that new cohorts of children will receive similar care. In countries where a health infrastructure already exists, A.I.D. will focus assistance on introducing or strengthening the ORT and immunization components of these systems and developing retail sales activities. In countries where it is lacking, A.I.D. will incorporate plans for developing the public and private infrastructure to undertake these child survival service programs.

UTILIZING THE PRIVATE SECTOR: Every effort should be made to explore opportunities for involvement of the private sector, to complement or supplement public sector programs. To the extent practicable, the private sector should be utilized to prescribe, distribute, and promote ORT and to produce the packets as well as to distribute vaccines. PVO's also should be used to implement programs where appropriate.

MODERN COMMUNICATION STRATEGIES: Although ORT and immunization programs already exist in many A.I.D.-assisted countries, lack of knowledge and low use levels persist. It is likely, therefore, that demand creation will be a key element of child survival activities. Experience has shown that modern marketing and communication techniques can be successfully applied to programs which have a social objective. Although mass media is apt to be part of most strategies, this must often be combined with person-to-person communication strategies. It is essential that demand creation efforts be carefully coordinated with adequate supplies and trained personnel. For ORS (oral rehydration salts, used in ORT), as for family planning, a social marketing approach should be considered.

SELECTED COUNTRY FOCUS

Currently, A.I.D. supports ORT and immunization activities in more than 50 countries. A.I.D.'s resources need to be concentrated to achieve maximum impact. During the next five years, A.I.D. will place special emphasis on programs in a selected number of countries where child survival problems are

especially severe in order to maximize the effectiveness of the services and their impact on infant and child mortality. A.I.D.'s child survival effort for the remainder of the decade will be concentrated in the following countries:

Bangladesh	Mali
Bolivia	Morocco
Ecuador	Nepal
Egypt	Niger
Guatemala	Nigeria
Haiti	Pakistan
Honduras	Peru
India	Senegal
Indonesia	Sudan
Kenya	Yemen
Malawi	Zaire

THE PROCESS OF SELECTING THESE COUNTRIES INVOLVED CONSIDERATION OF THE FOLLOWING FACTORS:

- Total number of infant and child deaths;
- Infant mortality rates;
- Immunization and ORT coverage levels;
- Mobilization and absorptive capacity (including accessibility of population and availability of mass media and infrastructure);
- Degree of government commitment to child survival, measured in terms of allocation of local resources and in terms of strong identification of local leadership (political, religious and other) with these efforts;
- Availability of funds from development assistance, ESF, Sahel and PL 480 and opportunities for programming these funds;
- Opportunities for effective donor collaboration aimed at achievement of common goals for improving child survival;
- Expectation that A.I.D. will continue to maintain a large program and sizable presence over the next three to five years.

IN THESE "EMPHASIS COUNTRIES," THE PLANNED A.I.D. COMMITMENT INCLUDES:

- Sustained bilateral funding for child survival activities for at least the next 3-5 years;
- A coordinated approach involving support for U.S. and indigenous PVO's, international organizations and other U.S. agencies such as the Peace Corps;
- Priority A.I.D./W support for the management and technical staff required to conduct child survival activities and for training to upgrade the skills of A.I.D. and host country staff.

This strategy is equally applicable to non-emphasis countries; however, the A.I.D. personnel and program resources for child survival activities in non-emphasis countries will be limited. Consequently, our efforts will have to emphasize policy dialogue and the influence obtainable through coordinated efforts with the donors. PVO's and the Peace Corps are also options for achieving child survival objectives in "non-emphasis" countries where A.I.D. bilateral programs and staffing are a major constraint. Even where there are no A.I.D. bilateral resources, we would expect child survival to be part of our policy dialogue in support of effective action by other donors and the host country to save children's lives.

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COLLABORATION WITH OTHER DONORS

A.I.D. and other donors (UNICEF, WHO, UNDP, PAHO, etc.) have joined together in the worldwide effort to achieve goals for both ORT and immunization by the end of the decade. By 1990, the infrastructure and programs should be in place to avert the deaths of two million children who will otherwise die from diarrhea and related dehydration. A.I.D. has also pledged to collaborate in an international effort to provide immunizations for all the world's children, with specific coverage goals defined at the country level. The challenge of meeting the internationally agreed goals and the inevitable limits on available funding means that we must strive to achieve maximum impact. Multi-donor collaboration at the country and sub-regional level is an important part of this international child survival effort.

Missions in the design of their country strategy and accomplishment of their program objectives should take fully into account the capacities of these other institutions. In this regard, a close program relationship has developed with UNICEF which has programs in many countries directly supportive of the A.I.D. strategy. The closest field coordination in support of country program goals is encouraged.

FUNDING

Funding for the Agency's child survival effort will come from funds earmarked specifically for child survival and the regular Health account. Population, Agriculture, Sahel, ESF and PL 480 accounts will also be used for child survival activities wherever appropriate.

PL 480 Title II and Section 416 programs can provide essential support for country child survival initiatives. Title II programs provide an excellent logistics system for transportation and distribution of supplies, particularly to and within hard-to-reach areas. It also provides established contacts with communities and vulnerable groups. Title II food resources can be used to prevent serious malnutrition and may be used in combination with ORT to manage diarrhea episodes and reduce rapid weight loss. The food may also serve as an incentive to bring mothers for other child survival interventions.

MONITORING AND EVALUATION

Very specific Agency objectives have been set for our child survival efforts. Monitoring and evaluation are an essential component of child survival activities. A.I.D.'s field missions are responsible for project management and program monitoring of their country programs. In addition, in collaboration with other concerned donors as appropriate, they will need to develop baseline data, benchmarks and a system of regular, at least annual, reporting on country specific child survival targets.

The Regional Bureaus will oversee and coordinate country performance. The Child Survival Task Force will monitor Agency performance and, in collaboration with other donors, track progress towards the world community's goals of universal immunization, access to ORT and reduced infant and child mortality.

Prepared Statement of Dr. A. Richard Jolly, Deputy Executive Director (Programmes), UNICEF

"Must we starve our children to pay our debts?"
President Nyerere of Tanzania

"A debt paid with poverty is an account paid with democracy"
President Sarney of Brazil

The 1980's: a decade of rising malnutrition?

The 1980s will almost certainly be recorded by future development historians as a decade of rising poverty and malnutrition in many if not most countries of the world. Certainly this is true for the vast majority of countries in Africa and Latin America. It is probably true also for many of the better-off countries in the Middle East. Even in the United States, Britain and some of the other industrialized countries, poverty has been rising, and often malnutrition among the poorest as well. Only in the economically-dynamic Asian countries can one be reasonably sure that malnutrition and poverty are declining rather than increasing, both as regards the proportion of the population affected and as regards the depth of poverty and malnutrition they experience.

What has been happening in the majority of countries is a widespread and marked deterioration in the human condition. The situation is one of a worsening of poverty and malnutrition, not merely, as for so long before, of its persistence. Nor, as often before, is it a matter of worsening poverty in some countries with improvements in others. The early 1980s have produced a strong, sustained and systematic set of downward international pressures on the majority of developing countries, with the consequence that living standards have very seriously deteriorated. There is still time for change, but without it the second half of the 1980s will be little better.

Statistical data on nutrition is rarely collected systematically, so that the evidence available is not comprehensive. Nonetheless we have evidence of serious and rising malnutrition in many parts of the world.

In Africa, malnutrition has increased significantly in the 1980s in Burundi, Botswana, Lesotho, Ghana and Rwanda (as the charts indicate) as well as in the worst drought affected countries of Ethiopia, Sudan, Chad and Mozambique. In 1984 in Ghana and Burundi over half the children under five were suffering some degree of malnutrition.[1] Rising malnutrition has been observed in Negros Occidental in the Philippines, badly affected by the collapse of the sugar price and in the estates in Sri Lanka. In Jamaica children admitted to hospital with malnutrition related diseases more than doubled between 1978 and 1985, and surveys show the aggregate level of malnutrition among children increased in both rural and urban areas.

The prime cause of hunger and malnutrition is low incomes, as the recent World Bank publication, Poverty and Hunger reports. But it is when low incomes are combined with declining incomes and poor health, that the worst manifestations arise. The economic crisis has reduced household incomes, and also reduced governments' capacity to provide health services.

Incomes have declined in many Third World countries, more than many people realize. In Latin America seventeen countries out of twenty-three had negative cumulative growth of per capita income between 1980 and 1985. In 1985, 16 countries had negative or negligible growth. In Africa, three-quarters of the countries had persistently negative growth of per capita income during the 1980s. In 1985 25 out of 32 countries had negative or negligible growth. For Africa, as a whole, GDP per capita in 1985 was 15% below that in 1980. Negative growth was also recorded in most countries in West Asia. Only in South and East Asia did significant growth occur in most countries in the 1980s.

Not surprisingly, this has lead to a widespread reduction in the real incomes of low income households, especially in the urban areas, with cuts in real wages (sometimes by as much as 40% or more) and rising unemployment that has accompanied the crisis. In Jamaica, for example, the unemployment rate has not fallen below 25% in the 1980s, while the real minimum wage amounted to only one-third of the expenditure necessary to meet minimum food needs of a 5-person household in 1984. In much of Africa, the situation was made worse by drought.

Falling incomes - and the need to pursue adjustment policies - have led to sharp reductions in government expenditures on social services in much of Africa and Latin America. In 14 countries in Latin America, the share of total government expenditure going to health and education declined (rising in only 4 countries), 1979-83. In Jamaica, total real expenditure on health in 1985-6 was 27% below the 1979-80 level, while real expenditure on education

[1] See Within Human Reach: A Future for Africa's Children, UNICEF 1985.

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fell by 10%. In Africa in 90% of the countries for which there is data, government recurrent expenditure per capita fell in the 1980s. In Ghana, 1983 real per capita expenditure on health had fallen by 90% compared with the level in the early 1970s. There have also been cuts in food subsidies in a considerable number of countries.

There have been some recent developments which improve the outlook for adjustment policies. In the first place, the sharp fall in oil prices has somewhat eased the problems of oil importing developing countries, but of course this has worsened the outlook for the oil exporting countries. Moreover, the very poorest will not gain much because they import relatively little oil. The international climate has also improved substantially with the move to support growth-oriented adjustment, led by Treasury Secretary, James Baker. Economic growth is essential, though by no means sufficient, for improving the health and nutritional levels of poor households in the medium term. A number of international institutions are showing increasing concern with nutrition during adjustment including recently the sub-committee on nutrition of the Administrative Committee on Coordination of the U.N.

Adjustment with a Human Face

It is therefore essential to make protection of the basic needs of vulnerable groups, and especially nutrition, an intrinsic part of adjustment policies. This is what UNICEF has described as "adjustment with a human face".[2] It is not only a human imperative but also sound economics to ensure the conditions for long term economic development. Human beings are the most important economic resource: investment in health and education can offer positive rates of return; healthy, well-nourished and educated children are the cornerstone of long-term economic development.

Adjustment with a human face is multipronged. It requires action to support incomes and productivity of low income households - both rural and urban - during adjustment; monitoring of nutritional standards and special interventions to help maintain standards where necessary, restructuring of government expenditures to protect social expenditure; and within the social sectors, restructuring towards low cost activities which maintain and improve the services provided for the most deprived. The precise action needed will vary according to country circumstances. A critical requirement, for all countries, is to institute a regular system of monitoring nutrition and health, so that emerging problems may be identified rapidly and appropriate action taken. More specific examples from particular countries may help to clarify the various approaches to adjustment with a human face.

Some country examples:

Botswana has instituted an Early Warning System to identify problems arising from drought, at an early stage. The system combines data on rainfall and agricultural conditions, with information on children's nutrition. The information is supplied to an Inter-Ministerial Drought Committee, which co-ordinates relief efforts. These efforts include supplementary food distribution to the vulnerable, with special programmes to feed children; work schemes, which are devoted to social and physical infrastructure; schemes to improve water supplies; and schemes to help agriculture, including provision of free seeds, and help with marketing cattle. With these measures, Botswana has managed to keep child malnutrition levels to around 20% in 1984, considerably below the levels reached elsewhere.

In Burkina Faso, one of the poorest countries in the world, a mass campaign in 1985 succeeded in immunising 75% of the children against measles, yellow fever and meningitis, at a cost of approximately $4 a head. This was achieved despite limited health infrastructure, by effective organisation and massive support from volunteers.

Tanzania, with the support of the Danish Government, has introduced an Essential Drugs Programme. This ensures supplies of basic drugs to the whole population, at a cost of roughly 30 cents a head. Tanzania introduced this scheme at a time of extreme financial stringency, when big cuts were being made in government expenditure, showing that it is possible to improve basic services in difficult times.

In Zimbabwe, the government has taken a series of measures to promote food security both at country and household level. The policies have included good incentives for farmers, with high producer prices announced well in advance; government support for irrigation and storage; and a focus on extension and credit on the peasant sector. The policies have been highly effective; the 1985/1986 crop shows a record crop with complete recovery from previous drought years; growth in peasant production has exceeded that of the large

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2. See also Richard Jolly "Adjustment with a Human Face".

scale sector. Zimbabwe is one of the few countries in Africa to have recorded a significantly positive growth in GDP per capita during the 1980s. The government has a strong commitment to the provision of primary education, extension of adult literacy and primary health care, and continued advance was recorded in the 1980s in each of these areas, despite economic difficulties.

Ghana has recently introduced very clear economic adjustment policies, in an effort to reverse the prolonged economic decline. Already, there are signs of economic recovery; there remains very considerable human deprivation among vulnerable groups, especially children under 5 and pregnant and lactating women. The Ghana Government has clearly recognized the need for the adjustment programme to incorporate social concerns, particularly in the next phase of adjustment. These would include low cost health interventions (mass immunisation is being initiated this month), rehabilitation of social and economic infrastructure by food-for-works schemes in the cities and in the especially deprived Northern regions of the country; support for small scale income generating activities and for village and household food storage; and much more emphasis on traditional agricultural crops in research, extension and credit. The ultimate aim must be to restore the economic conditions for low income households to meet their own food needs, while providing comprehensive coverage of health, education services, water and sanitation, at low cost.

South Korea has managed to combine economic growth and adjustment while expanding support for vulnerable groups. Stabilization measures introduced in the early 1980s succeeded in drastically reducing the budget deficit, while the deficit on current account fell from $1.1b (1980) to $1.4b (1984) and prices have been stabilised. Per capita GNP increased by 25% over this period. At the same time, expenditures on the social services rose from 25% to 29% of government expenditure. Health insurance coverage was extended to 41% of the population, from 11% in 1978; and medical aid from 6% (1978) to 8% (1984). Basic assistance is given to the absolutely poor under the Livelihood Protection Programme: in 1982 2 million people received benefits. The Country Primary Health Demonstration Project has extended the health care system throughout the country. In addition, off-farm employment activities are being created in the rural areas to help offset regional disparities.

In the Philippines, the present political and economic situation demands an adjustment programme incorporating the human dimension. In recent years great poverty has arisen - with rising rates of infant mortality and child malnutrition - in certain regions of the country and in the urban slums. The new government is determined to reverse the social and economic decline. An economic recovery programme focussing on small-scale and labour-intensive production processes and small farmers would permit economic growth to be combined with increased equity and diminished poverty in the medium term. In the short run, rural and urban works programmes could create jobs and restore social and economic infrastructure, improving long run productivity, while some extension of special feeding schemes for infants and children is likely to be necessary to meet immediate nutritional deficiencies. The Philippines offers a challenge where adjustment incorporating the human dimension is a political as well as a human and economic imperative.

Child Survival and Development Revolution (CSDR)

Finally, let me emphasize the close relationship between UNICEF's focus on the Child Survival and Development Revolution (CSDR) and the issue of adjustment with a human face. CSDR consists of widespread promotion of low cost health measures which can massively improve child health. These include the objective of universal immunisation by 1990; extension of oral rehydration therapy; child monitoring; encouragement of breast feeding; and improved pregnancy management. These CSDR activities are an essential part of adjustment with a human face. They are low cost and permit great advances to be made in infant and child health, even at a time of declining incomes and economic crisis. But if the economic crisis is not accompanied by policies to protect vulnerable groups, its effects may offset, in part or even whole, the positive effects of CSDR. Incorporating the human dimension in adjustment is, therefore, an essential complement to CSDR, while CSDR is itself part of broadening concern with the human dimension in the implementation of adjustment policies.

I know that Members of the Select Committee are familiar with the opportunities - and the dramatic progress - of the Child Survival and Development Revolution in the three years since UNICEF first articulated the possibility. A fairly up-to-date review can be found in The State of the World's Children, 1986, which we released here in Washington this past December. May I also direct attention to the excellent USAID publication, Child Survival: A Report to Congress on the Aid Program, published last December.

Progress over the last 18 months in both immunization and diarrhoea disease control has been especially encouraging. Some 61 countries now have prepared or embarked upon serious plans for achieving universal child immunization by 1990. World vaccine used last year had increased to three times and ORT use to 2 1/2 times the levels achieved in 1983. These are remarkable increases at a time of severe economic constraints - and show the beginnings of a restructuring within health expenditure, so badly needed.

In this respect I must note the special urgency of providing adequate external financial resources to support these actions, already encouraged by the United Nations, USAID, and many other bilateral agencies, and a wide range of private organizations. The additional $80 million per annum which this Committee has proposed would provide critical support for advancing the UCI-1990 effort. Perhaps I might also add here that any lessening of the United States regular contribution to UNICEF would be a severe blow to UNICEF's role in the Child Survival movement.

As the economic crisis appears likely to be prolonged throughout the 1980s for many countries, the need to incorporate a human dimension into the adjustment effort becomes even greater. As more and more countries seek international support for their adjustments, there is increasing opportunity for international leadership in this area.

U.S. support for adjustment policies which protect the most vulnerable needs to be added to the call for more growth-oriented already emphasized by the U.S. Government. The U.S., as a major bilateral donor can play a valuable role in supporting projects - as well as policies - to protect the vulnerable during adjustment.

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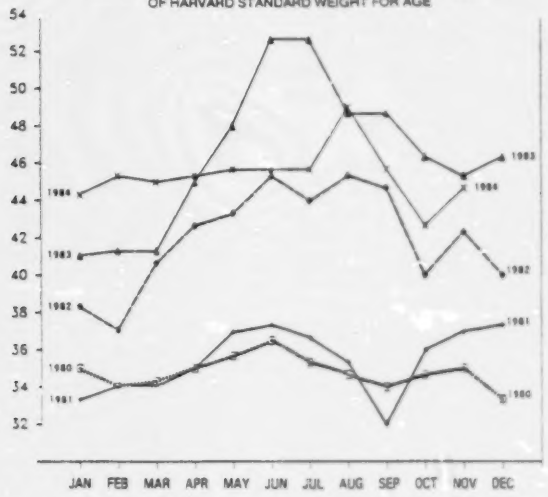
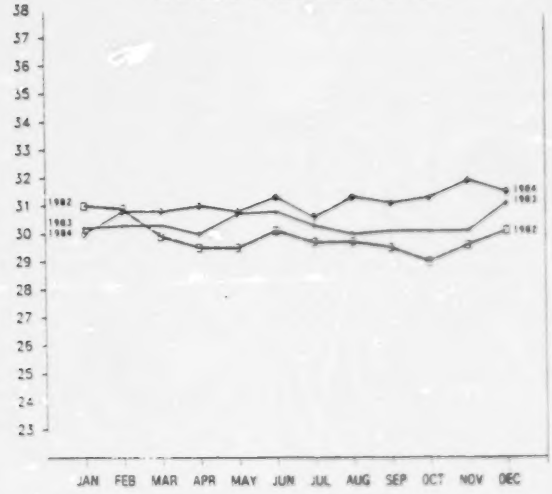
GHANA: % OF UNDER 5'S BELOW 80%
OF HARVARD STANDARD WEIGHT FOR AGE



Source: Catholic Relief Services, Kenya

RWANDA: % OF UNDER 5'S BELOW 80%
OF HARVARD STANDARD WEIGHT FOR AGE



Source: Catholic Relief Services, Kenya

BURUNDI: % OF UNDER 5'S BELOW 80%
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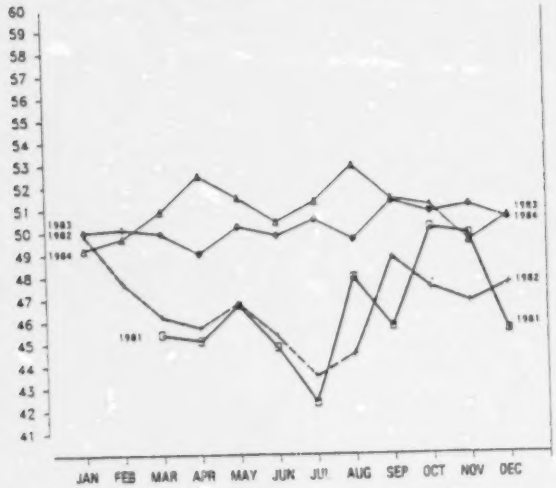

Source: Catholic Relief Services, Kenya

MADAGASCAR: % OF UNDER 5'S BELOW 80%
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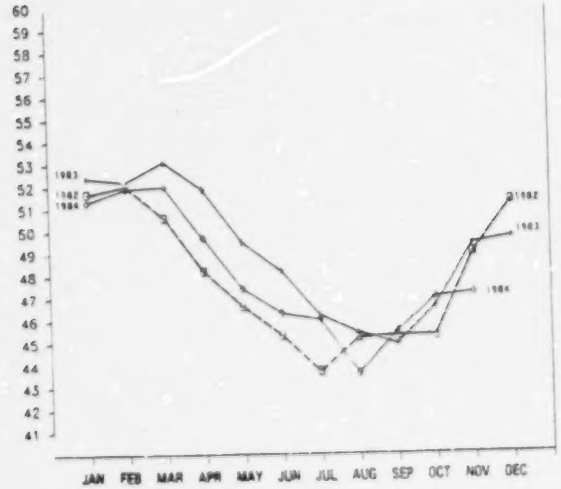
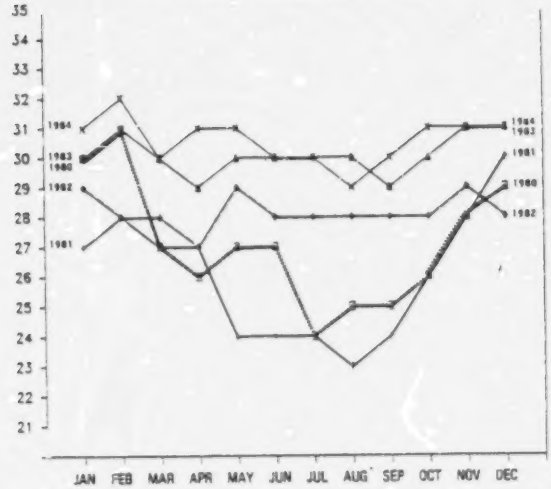


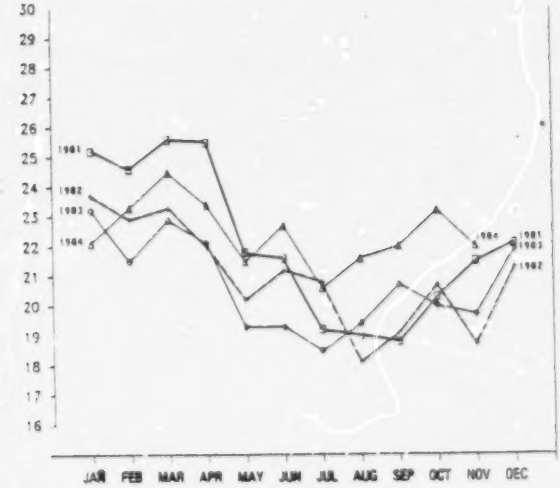
Source: Catholic Relief Services, Kenya

BOTSWANA: % OF UNDER 5'S BELOW 80%
OF HARVARD STANDARD WEIGHT FOR AGE



Selected Background Papers for Workshop on Socio and Nutritional Surveillance in Eastern and Southern Africa' UNICEF Socio Statistics Bulletin, Vol. 5

LESOTHO: % OF UNDER 5'S BELOW 80%
OF HARVARD STANDARD WEIGHT FOR AGE



Source: Census Head Surveys, Kenya

Prepared Statement of Abdoul Salam Kabore, Minister of Health, Burkina Faso

Ladies and gentlemen, I am honored to be able to address you today. My first words are to extend our thanks and appreciation for inviting me to attend and participate in this forum.

HEALTH PROBLEMS IN BURKINA FASO

Despite the efforts undertaken in the health sector, the medical situation in Burkina Faso remains precarious. The current situation is linked to the fact that the governments which preceded the National Council for the Revolution did not give proper priority to the health of the population.

In the past, health was always considered an unproductive sector without impact upon socio-economic development, explaining Burkina Faso's alarming principal health indicators today: The general mortality rate is 25.8 per 1,000; infant mortality is 182 per 1,000 live births; and life expectancy at birth is 42 years in the urban centers and only 32 years in the rural areas.

Burkina Faso's main public health problems may be grouped in five categories:
*A high prevalence of communicable diseases which cause high rates of morbidity and mortality
*Nutritional deficiencies
*Insufficient water supply and sanitation
*An insufficient and poor distribution of equipment and medical-sanitary infrastructure
*Lack of qualified personnel.

NUTRITIONAL DEFICIENCIES

Suffering from a decade of drought, Burkina Faso, like other African countries, currently faces a critical food shortage, of which the direct health consequence is malnutrition, affecting women and children in particular.

Among the principal nutritional deficiencies are:
*Protein-Calorie Malnutrition: Our statistics and research reveal that 40 percent of children under five years of age are malnourished, of which 2 percent are severely malnourished. These figures, considerably below the standards set by the World Health Organization, attest to the gravity of the situation.
*Nutritional Anemias: Associated with protein-calorie malnutrition, nutritional anemias affect one of every two women, one child in three, and one man in five, considerably reducing our productivity.
*Vitamin A Deficiency: Endemic in all our provinces, vitamin A deficiency is responsible for nutrition-associated blindness.
*Goiter: This debilitating disease, which is also endemic in our country, has a prevalence of more than 10 percent and is particularly menacing in the central and southwest parts of the country.

Because of its gravity and its high prevalence, malnutrition is on its way to becoming the major public health problem of Burkina Faso. Malnutrition affects that part of the population which is most vulnerable--women and children--representing a decrease in human capital without which we cannot hope to develop our country. This nutritional situation is all the more serious when it interacts with the high prevalence of communicable and infectious diseases, such as measles, malaria, diarrhoea, meningitis, and tuberculosis.

An unhealthy environment is also a source of numerous communicable diseases. The rate of excreta disposal, for example, is 30 percent in urban areas and only 5 percent in the rural areas.

The lack of a safe and adequate water supply is so critical a problem that only 35 percent of the population has drinking water available within a five-minute walk of their homes. In urban centers, only 50 percent have the benefit of a water installation.

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Throughout the country, the following health facilities are available to the population:
*7,500 primary health posts, which have recently been installed at the village level
*126 dispensaries
*29 maternity clinics
*281 centers for health and social promotion (clinics)
*59 medical centers (small hospitals)
*5 regional hospital centers
*2 national hospitals.
In all, these health facilities provide a total of 5,623 beds, of which 2,297 are maternity beds.

Burkina Faso has only one medical doctor for every 44,000 inhabitants, one pharmacist for 85,160, one midwife for 53,701, and one nurse for 4,768. The standards recommended by WHO are one medical doctor for 10,000 inhabitants, one chemist for 20,000, and one midwife for 5,000 inhabitants.

Faced with these numerous health problems, the government of Burkina Faso, which came to power on August 4, 1983, has developed a policy which guarantees health for all by mobilizing the population. In order to reach our objective of "Health for All," we have committed ourselves: to establish an adequate system of maternal and child care; to an immunization policy against communicable diseases through expansion of vaccination campaigns; and to a program of mass education for good hygiene.

Cognizant of the fact that sick people cannot be productive, we are committed to undertaking certain priority actions. These have already proven fruitful in the vaccination sector, where our "Operation Vaccination Commando" campaign achieved considerable success.

During a 15-day period, this operation was able to vaccinate:
*1,184,412 children in the 0-14 age group against measles (59 percent of target group coverage);
*2,110,230 children against yellow fever (62 percent target group coverage); and
*2,572,834 children against cerebro-spinal meningitis (64 percent target group coverage).
The "Vaccination Commando" campaign was termed "foolish" when it was proposed to the international donors.

The creation of a primary health post in each of our 7,500 villages during the period of November 1985 to January 1986 has permitted us to make primary health care available to all the population. These village health posts provide the mechanisms to introduce educational and preventive activities, while calling on the participation of individuals, families, and communities to be responsible for their own health.

Our Popular Development Program of 1985 has allowed us to decentralize pharmaceutical distribution through the construction of 107 drugstores and five regional pharmaceutical dispensaries throughout the country. A National Society of Pharmaceutical Supplies has been created for the centralization of purchases, which has allowed us to exercise more control over the importation of medicines, achieve economies of scale in their wholesale purchase, and maintain a more stable stock of medications in the country.

Steps are being taken to promote the health of our workers through our program of occupational health, a service available to each worker at his place of employment.

In addition to the existing health risks we are facing, there are also the threats of tobacco, alcohol, and drug abuse. We are vigorously fighting against these abuses by an extensive publicity campaign, for example, on the dangers of tobacco usage, and by simultaneously providing a good health education. We welcome the World Health Organization's 1986 slogan, "Healthy Living, Everyone a Winner," which has enabled us to undertake efforts in the area of health education.

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Our struggle to promote health, particularly against the new risks mentioned above, is nothing less than a fight for our independence from the adverse effects of multinational enterprises in the Third World. Cigarettes sold in the developed countries bear a label, "Cigarette smoking is hazardous to your health," and the amount of tar and nicotine in each cigarette. But curiously, the cigarettes imported by the developing countries do not have the same label. The developed countries know the kinds of medications they are supplied with. However, some drugs which have been taken off the market due to undesirable effects are still sold in developing countries.

The promotion of health in Burkina Faso is also aided by actions the government has taken in other socio-economic sectors. For example, malnutrition problems cannot be resolved without self-sufficiency in food supply. The government has therefore undertaken an ambitious program of farmer organizations, land reform, integrated agriculture, and construction of irrigation works.

Implicit in each development effort is education and information, and a large-scale literacy program is currently being implemented.

The government has organized a vast program of village and rural water supply with an aim to provide safe and sufficient water for each citizen. Guinea worm disease, which breeds in dirty water, cripples working adults and children in large numbers at critical times of the year when they must be available for planting and harvesting crops. Thus the disease has a severe adverse effect on health, agriculture, and education.

Burkina Faso is one of the African countries most seriously affected by guinea worm. In 1985, the government of Burkina Faso began efforts to effectively combat this disease, setting up a national commission to control it. Research on the effectiveness of health education, water supply, and vector control in combating guinea worm disease is being conducted at the Centre Muraz in Ouagadougou. It is known that guinea worm disease can be eliminated.

As far as accommodation is concerned, our policy is to ensure decent housing for each Burkinabe family. The government has committed itself to zoning and toward this end, a construction company and a popular housing bank have been created.

Concerning the hostile environment, the government has committed itself to a three-dimensional fight against desertification by: controlling bush fires, fighting against the abusive cutting of trees, and halting overgrazing by cattle and other stock animals. Every official visitor to Burkina is asked to plant a tree. Each Burkinabe must plant a tree at joyous occasions such as the birth of a child or a marriage.

Everyone is involved in Burkina. Women have been mobilized to assist in the development. Women have been promoted to high governmental positions and there are three women ministers at the present time.

None of these activities could have been undertaken without an adequate organizational structure including: the Committees for the Defense of the Revolution (CDRs); the Union of Women in Burkina Faso; the Directorate of Mobilization and Organization of Women; and the National Union of Elders of Burkina Faso.

FUTURE PERSPECTIVES

Even given the actions we have taken to make up for lost time in providing health services for our population, much remains to be done to meet our goal of health for all by the year 2000. Toward this end, our five-year development plan for 1986-1990 has emphasized the reinforcement of primary health care in the following areas:

*strengthening of health infrastructure

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•maternal and child health, family planning, and nutrition programs
•a control program for major endemic diseases
•a program of health education, sanitation, and hygiene
•a program of pharmaceutical supply and traditional medicine
•a program of occupational health
•a program of pre-service and in-service training.

The total cost of the five-year plan amounts to nearly 23 billion FCFA, or about U.S. $63 million. Conscious of the fundamental role which health plays in the socio-economic development of the nation, the government has undertaken all necessary steps to finance the five-year plan.

As you may observe from this report, the health status of my country, inextricably linked to our socio-economic situation, requires a substantial and sustained effort on our part. We are confident of success in our battle to improve the health of our people, for they themselves are determined to be free from the misery and poverty which continues to afflict our nation. As no people can entrust their development to others, Burkina Faso is committed to make the necessary sacrifices, first and foremost calling on its own financial and human resources to this end.

The aid we receive from our friends, including goodwill and cooperation, will encourage us in these efforts, but no people should depend solely on others.

Ladies and gentlemen, I cannot end this statement without thanking the American people on behalf of our people, the National Council of the Revolution, and our government for the honor you have bestowed on me by inviting me to participate in this forum. Thank you for your kind attention.

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Prepared Statement of John H. Costello, Executive Director, Helen Keller International

I am John H. Costello, Executive Director of Helen Keller International. My purpose today is to speak for the hungry children of the world. For their sake, I urge Congress to renew and increase its support for their survival. Most especially, Mr. Chairman, I ask your Task Force and this Committee to continue to spearhead the eradication of Vitamin A deficiency. This insidious, invisible nutritional deficiency affects 30 million children every year, stunting their growth, drying their eyes, and robbing them of resistance to infections that take their lives.

Almost a year ago, Dr. Alfred Sommer, Professor of Ophthalmology at Johns Hopkins University and a Medical Advisor for Helen Keller International, and I appeared before the House Select Committee on Hunger to speak about the importance of the Congressional Child Survival initiative and to highlight the sight-saving and life-saving qualities of vitamin A.

Once again we want to express our appreciation to you, Congressman Leland, and to Congressman Hall and your colleagues for your positive reaction then to the news that a two-cent megadose capsule of vitamin A, delivered twice annually to malnourished young children in developing countries, can save 500,000 youngsters from blindness each year and, even more importantly, save the lives of millions.

Your Staff Report on the significance of vitamin A for child survival and your effective leadership in securing a special earmark for increased vitamin A supplementation has had a tremendous impact throughout the world. It served to generate increased awareness and commitment to vitamin A supplementation initiatives by international agencies, corporations, and private voluntary organizations. The World Health Organization is planning a global program to control the vitamin A deficiency that threatens children in 73 countries. Major American PVO's like CARE, Save the Children, Africare, and Meals for Millions will include vitamin A supplementation and nutrition education in their child survival activities. UNICEF, which has long played a key role in vitamin A capsule distribution, I'm pleased to say, is renewing its attention to the role of vitamin A in child health. Furthermore, it is particularly gratifying to note the increasing commitment of the private sector. Hoffmann-La Roche, a major manufacturer of vitamin A, has pledged financial and technical resources to assist our efforts on a broad scale.

All of this has allowed Helen Keller International to mount major new vitamin A programs in Indonesia and Bangladesh in 1985-86. These programs will, of course, provide vitamin A supplements to legions of children who need them. Furthermore, we are confident that the research component built into each of these programs will corroborate our previous AID-funded studies. These studies demonstrate that children with symptoms of nutritional blindness--these are the first clinical signs of vitamin A deficiency--have four times the risk of dying when compared to children with no clinical signs of vitamin A deficiency, and that child mortality is reduced 30 percent overall in children who receive high-potency vitamin A capsules semi-annually.

Helen Keller International has been planning for several months now to launch a second wave of vitamin A supplementation programs that will reach an estimated 20 million children a year, over the next three years, at a projected cost of 65 cents per child per year -- while, at the same time, addressing the need for permanent solutions to widespread vitamin A deficiency through nutrition education, social marketing, and food fortification.

This Helen Keller International initiative is spelled out in detail in a three-year grant proposal submitted only last week simultaneously to the AID offices of Private Voluntary Cooperation and T/A Nutrition. Because of the Congressional recognition last year of the significance of vitamin A for the well-being of the world's children, and because Helen Keller International is the world's most experienced operational

institution for vitamin A technology and programs in developing countries, we feel a special responsibility to assume a leadership position.

The approach we have outlined to AID has three principal aims:

1. Capitalize on our major program investments in Indonesia and Bangladesh, where we and AID have collaborated successfully for a number of years. Vitamin A deficiency is still widespread in each country. Government and local institutions are committed to addressing the problem.

   We are uniquely positioned to take the efforts in each country to a national scale--achieving a dramatic and lasting impact on nutritional blindness as well as on child mortality and morbidity.

2. Initiate major new initiatives in countries where vitamin A deficiency is widespread and infant mortality rates are particularly high, and where we have a chance for significant success. These countries are the Philippines, in Asia; Sudan, Mali, Burkina Faso, and Niger in Africa; and Haiti in our own hemisphere. The Philippines are an important priority. Helen Keller International is currently working in one province, but vitamin A deficiency throughout the country is devastating. The new government is eager to address the problem, and the tools to do so in terms of commitment, technology, and food resources are at hand.

3. Rapidly increase vitamin A supplementation and nutrition education for millions of children at grave risk of malnutrition, respiratory, and diarrheal disease by providing technical assistance and training to a range of institutions--particularly PVO's--now involved in feeding, maternal and child health care, child survival, and small-scale agricultural initiatives. This approach will be particularly important in Africa. Helen Keller International is now recording alarming rates of nutritional blindness in countries where infant mortality rates are among the highest in the world. Given the scope of the problem and the economic and structural realities in Africa, the best hope for fast, large scale, low-cost impact is to pursue the integration of vitamin A activities within a wide range of nutrition, child survival, and agricultural programs. CARE, Save the Children, Africare, and Meals for Millions--agencies with active programs reaching large populations--have already contacted Helen Keller International to request assistance for including vitamin A in their expanding efforts in Africa.

I am pleased to report to this Task Force that the prime-time ABC-TV magazine show "20/20" recently visited the Philippines to document the problem and to tell the American people of the important role that low-cost vitamin A can play in saving the lives of countless Filipino children. Hugh Downs, who chose to report this story himself, asked me to tell you this: "There is great personal as well as professional satisfaction in my being able to report from remote villages in the Philippines on the work of Helen Keller International in meeting the crucial health needs of small children suffering vitamin A deficiency. These children are not only at high risk as far as their eyesight is concerned, but the importance to their general health of getting them supplemental vitamin A, and of educating parents on the availability of vitamin A in plants that grow in their own yards, is an intervention of enormous life-saving potential for very little cost." The story is scheduled for broadcast to an estimated 25 million viewers in mid-June.

We hope that AID will issue a timely and positive response to our request. We have within reach a wonderful opportunity to program a small amount of resources for a maximum effect. By capitalizing on what is well under way, and by sharing our knowledge and experience with other institutions, we can save the sight and lives of millions of children.

Congress is to be congratulated for creating the Child Survival fund last year, and AID is to be commended for assigning private voluntary organizations to expedite its aims. The action taken by you, Mr. Hall, and by Mr. Leland and your colleagues to insure a strong nutrition component within total child survival strategies has certainly been a life-saving force for millions of children. Beyond that, and beyond the actual funds allocated, it has provided global visibility and a momentum that is just beginning to swell. As a result of your leadership, institutions around the world are recognizing the importance of vitamin A and are considering allocation of scarce resources.

I urge that this special allocation of funds be continued in the next fiscal year, particularly the funds earmarked for vitamin A. The lack of an earmark will send a signal that nutritional interventions are not key to child survival strategies. ORT (oral rehydration therapy) and immunizations--the principal emphases of child survival interventions--cannot achieve full success without improving basic nutritional status as well.

Malnutrition triggers a vicious cycle: It deprives children of the energy they need in order to grow. It weakens their immune system. It leaves them vulnerable to febrile, infectious, and parasitic diseases that futher deplete their meager energy stores, and further suppress their immune systems. This cycle sends already debilitated children further along on the road to death.

The role of vitamin A in this dreadful scenario of malnutrition is becoming increasingly recognized. An adequate diet of vitamin A is critical to insure a child's resistance to the respiratory and diarrheal diseases that--though they are trivial in our country--kill children in the Third World. And, we suspect, vitamin A has a larger role in the general immune response system.

Vitamin A supplementation is truly critical for child survival. Hugh Downs calls it "The health story of the year." The lack of an earmark, which would serve to cloak the urgency of this matter, would also undermine the intent of Congress's child survival initiative.

Thank you, Mr. Chairman, for giving me the opportunity to present this testimony today.

PREPARED STATEMENT OF ALFRED SOMMER, M.D., DIRECTOR, DANA CENTER FOR PREVENTIVE OPHTHALMOLOGY, THE JOHNS HOPKINS MEDICAL INSTITUTIONS

Chairman Leland and distinguished Members:

I am honored by the opportunity to discuss progress in our understanding of the consequences of vitamin A deficiency and methods for its control since my testimony of last year.

Evidence implicating vitamin A deficiency as an important contributing factor to childhood illness and death throughout the developing world continues to mount. The important studies of the impact of vitamin A supplementation in northern Sumatra, Indonesia, have now been completed. The first of a series of scientific reports will be published next month in the respected medical journal, the Lancet. These indicate that as a conservative, minimal estimate, childhood mortality in villages which had not yet begun programs to distribute vitamin A capsules (200,000 IU) every six months was one and one half times the rate among children in program villages. In other words, from the reverse perspective, vitamin A capsule distribution was associated with a reduction in childhood mortality by at least 35 percent. Another analysis, not yet published, suggests this may underestimate the potential impact of vitamin A supplementation. Not all children in the program villages actually received their assigned capsule. While most children in program villages did receive the capsule, most deaths in program villages were among the small group of children who did not. This strongly suggests that vitamin A supplementation of populations like that of northern Sumatra might well reduce childhood mortality by 50 percent or more. In addition to its impact on child survival, the risk of potentially blinding xerophthalmia in program villages was reduced to one-fourth that of control villages.

A second supplementation study was also recently completed in Indonesia, on the island of Java. In this instance rather than capsules, vitamin A intake was increased by fortifying a commonly consumed condiment (monosodium glutamate). Reduction in xerophthalmia and mortality rates were comparable to those in the capsule study, despite the different means of supplementation, a distance of 1200 miles between study sites, and vastly different cultural conditions.

Even more supportive were the results of a hospital study in Tanzania. Measles is the major cause of childhood blindness and certainly one of the most serious and severe illnesses among African children. Exactly why African children commonly have severe complications from measles is as yet uncertain, but in-hospital mortality rates often average 2-6 percent. On the theory that vitamin A deficiency may play an important intermediary role, half the measles children admitted to one hospital received routine treatment while the other half received, in addition, two large doses of vitamin A. Mortality among the vitamin A recipients was only half that of the other children. This dramatic impact coincides with mounting evidence that vitamin A deficiency is common in many areas of Africa.

Results of the Indonesian studies have been influential in interesting various agencies of the United Nations to re-evaluate their priorities and increase commitments to combatting vitamin A deficiency as one of the most cost-effective means of reducing childhood morbidity and mortality in the developing world. At its 12th session, held in Tokyo on April 7-11, the Subcommittee on Nutrition of the United Nations Administrative Committee on Coordination (ACC/SCN) reviewed the Indonesian studies and issued a "Statement on Vitamin A and Mortality." Among other points they concluded:

> "There is justification to expect the effects of this magnitude (approximately 30 percent reduction in mortality) would be seen in other settings with similar conditions..."
>
> "It is appropriate to advise countries mounting high dose vitamin A programs for the control of xerophthalmia, that reduction of child mortality is a reasonable expectation..."

"The AGN notes that confirmatory trials are now in process, and urges that these be monitored to ensure that the experience in Indonesia is reproducible in other regions which may have different patterns of morbidity or other conditioning factors."

The United States Agency for International Development was instrumental in awakening interest and providing the funds needed to carry out the research work that has provided this important new information. USAID has also committed itself to support "replication" trials needed to further confirm and extend our understanding of the potential impact of vitamin A supplementation on maternal and child health, and on infant and preschool morbidity and mortality. The first of these trials, perhaps the largest and most ambitious that will be undertaken, is just getting underway in the Philippines as a joint undertaking of their Ministry of Health, the Johns Hopkins University and Helen Keller International, with financial and administrative assistance of USAID (both from S/A Nutrition and the local Mission). Continuing support for these investigations, the development and pilot testing of imaginative, effective and cost-efficient supplementation strategies appropriate to local conditions (as with MSG fortification noted earlier), and implementation and evaluation of nationwide and regional intervention programs is not only essential, but carries a very high probability of saving the sight and lives of millions of children throughout the developing world.

Meaningful progress requires, above all, your sustained support.

Thank you for your interest and assistance.

Prepared Statement of Dr. Warren L. Berggren, Director, Primary Health Care, Save the Children Federation

Mr. Chairman, members of the Task Force, my name is Warren Berggren. I am a physician, my speciality is Public Health. I have practiced 16 years in rural villages of developing countries and, during the rest of the 30 years since I became a physician I have been either teaching, doing research in health, consulting or seeking funds for health projects in developing countries, I serve full-time as Director of Primary Health Care for Save the Children Federation.

Save the Children is an international child assistance and community development organization based in Westport, Connecticut. We are one of thirteen private voluntary organizations who received grants from the Child Survival Fund for fiscal 1985. I am pleased that you invited me today to tell how we are promoting child survival, what we are doing with Child Survival funds and how we could do more than we are.

Save the Children promotes development by training families and communities in skills that promote self-reliance to earn a living, improve their quality of life and protect their children. Training to protect children must focus on what is most likely to kill or disable a child in its particular community of residence. Parents and community institutions can then be taught the specific skills that will prevent deaths or disabilities. They can also learn to motivate each other to practice these child-protective skills appropriately. Care for diarrhea is an example. Families can learn to use household materials to prevent diarrhea from leading to dehydration and finally to death. When whole neighborhoods learn this skill as a group, they can encourage each other to practice it correctly, and in a timely manner.

Save the Children has identified ten skills that would enable families in each SCF impact area to protect their children better than they now do. Although families may learn complete self-reliance in care for diarrhea, malnutrition, certain water born diseases, etc., the practice of certain other child-protective skills requires the assistance of persons with specialized qualifications and materials. Vaccines, for example, must be purchased, transported and kept cold until they are administered by qualified personnel with appropriate equipment. A personal record of vaccination must be kept by the family. All members of the community who can benefit from the vaccination must be contacted to achieve as complete a coverage as possible. Most of the process depends on families and their community organizations but significant responsibility rests with government health employees. They must deliver a valid vaccine and perform an aseptic injection in a place and at a time that is accessible to those requiring vaccination. Save the Children therefore seeks all ways open to it to assist government agencies responsible for health to strengthen their skills and improve their performance of services related to the protection of children.

Vaccination is also representative of that group of child-protective skills which must be supported in a continuing fashion for many decades, if not forever. I was saddened recently to see a national vaccination program not implemented by our organization, I hasten to add, which is now achieving a lower rate of vaccination than previously. The refrigerators, purchased a few years ago at considerable cost, are not regularly supplied with kerosene. Syringes and needles are reused without appropriate sterilization. The lesson remembered from the experience is that training and support for families to seek immunization services requires follow-up. Three years is a good beginning but long-term planning and support is essential to success of several child protective practices.

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Finally if mothers are absent, ill or dead, their children run enormous risks of death and disability; so mother's health is essential for child health. In some cases this relationship is extremely direct. For example, in some rural areas the only certain way to prevent tetanus of new-born infants is to vaccinate women against tetanus long before they deliver their babies. The antibodies produced by the mother pass through the placenta and passively immunize the child before birth. Protecting mothers is approached in the same manner as protecting children. Thus, as relevant skills are identified, families are trained to practice them and the community institutions are trained to support the family in their practice of these skills.

After this extremely brief sketch of how Save the Children works, let us describe what we have done with the Child Survival funds which we were granted in Fiscal Year 1985. These funds were released to us just eight months ago. During the first four months we attended a conference convened by USAID and then wrote the detailed implementation, monitoring and evaluation plans required by AID project guidelines.

During the past four months we have recruited and trained the national personnel in each of our five countries that are supported with these child survival funds. We have also acquired most of the materials and equipment. Acquiring equipment has been a major problem because U.S.-built vehicles are not available in some of our countries and as of today, we have still not received from AID the waiver which will permit us to buy the vehicles that are available in the country. In desperate attempts to meet commitments made to communities and ministries of health, we have rented and borrowed vehicles. We would sincerely appreciate help in shortening the process of obtaining the necessary waiver because every day's delay takes its toll in lives of children who are dying of preventable conditions.

In contrast to the schedule given above, we began serving 330,000 people in Ethiopia with private funding a year and a half ago. We enrolled every family in the population and assessed the nutritional status of each family member. We delivered food to the villages of the famine stricken families, taught them to rehabilitate their malnourished family members, provided them appropriate agricultural seeds, trained them in child protective skills and assisted them to improve their water sources and roads through self help. In eight months the crude death rate calculated on an annual basis had fallen from 100 per 1000 persons to less than 10 per 1000 persons. Families grew food, rehabilitated their malnourished family members, treated cases of diarrhea and malaria and trachoma, vaccinated all their children aged 0-2, improved their wells and constructed 250 miles of dirt road. By so doing 18,000 of them escaped death due to starvation and disease.

Complete vaccination coverage and training in oral rehydration therapy were envisaged by the Ethiopian Ministry of Health but their achievement before 1990 had been thought impossible. The achievement will be sustained through collaboration between the Ministry of Health and the communities formed by the 330,000 rural people. Catalysis of this collaboration is one of Save the Children's critical outputs in its program of sustainable solutions to long-term needs. Save the Children has begun similar child-protective programs with private funds in fourteen other countries. These programs serve approximately half a million people. Each of them could reach more people at a faster rate if additional funds were granted to them.

We recognize that serving 1.3 million people meets only a tiny fraction of the world's need for primary health care but we believe that our assistance is meaningful, not only to those beneficiaries but also to their compatriates. In every country we plan and work closely with Ministries of Health. We employ young professionals from the nation in which we work and we engage them in the solution of important national health problems. Our model for health care is original and has potential to permit rapid expansion of cost-effective health care to large populations. Natural adaptations of this model and the skills acquired by young national professionals, therefore, are likely to benefit many more than the presently targeted beneficiaries.

In the 49 countries in which Save the Children works, twenty two of our field offices presently have an acute need for Child Survival funds. We have the competence to use them appropriately and the capacity to match them with private funds. In five of the countries we were granted Child Survival challenge funds in Fiscal Year 1985. Four of the remaining seventeen countries are on AID's nine country eligibility list for the FY 1986 competitive challenge grant proposals now being considered. Thus, we may get help with these four countries and would then be down to only thirteen countries where our capacity to make a meaningful impact on child health and survival is limited only by our lack of funds.

Permit me one more point on behalf of all the U.S. Private Voluntary Organizations who have applied for Child Survival funds. We are all indeed grateful for this opportunity to do more than we have already done in the past to save the lives and health of children. In return, however, your constituencies who are providing the challenge grant money are getting a fantastic bargain. All of us Private Voluntary Organizations have pledged to implement, at the grass roots level, health technology of proven capacity to change the rates of mortality and disability among children. We have also pledged to report our results in terms of lives saved. We have accepted the reporting system instituted by USAID which will assure that our impact on child survival will be measured. The reporting system is so rigorous that only a few researchers, myself among them, have experience in making it work in the past. We are not research organizations but we accept this challenge because we want this opportunity of survival for children.

In summary, fifteen percent of Child Survival funds for FY85 and 86 have been allocated to Private Voluntary organizations who will use well proven methods at the grass roots level and report to you the number of lives saved.

We are aware that the other 85% of Child survival funds for FY85,86, approximately $104 million, has been allocated to other organizations and agencies. We urge that these organizations be held accountable in terms of impact on child survival in the same way as we Private Voluntary Agencies are. We hope that they, with the lions share of these funds, are giving you as good a bargain as we are. Perhaps the research, technical assistance, consultation and bilateral aid will have as great an impact on child survival as the PVO grass roots level projects. We would have liked to have heard their reports this afternoon. They might change our way of working. Surely, we believe you, Mr. Chairman, and members of the Committee, would like to know what their impact might be since it concerns 104 million dollars of money which you worked very hard to reserve for a very important purpose.

Prepared Statement of Dean R. Hirsch, Director, World Vision Relief Organization

Good morning, Mr. Chairman, Honorable Members of Congress, and respected guests and colleagues. My name is Dean Hirsch, and I serve as Director of World Vision Relief Organization (WVRO). I appreciate the opportunity to share with you today on behalf of World Vision and the hundreds of field staff, project workers and community trainees who are seeking to share together in the goals embodied in the Child Survival Initiative.

World Vision is an international Christian humanitarian partnership representing twelve support countries which fund 3290 projects in over eighty countries. Our involvement in health care began with Asian orphans in the early 1950s, focusing on medical care, health education and immunization. As our organization has grown, we have increasingly realized the critical role that health care plays in effective and sustained development, as well as emergency relief. World Vision currently operates 1,416 health-related projects worldwide which represent a total budget of $26,160,759 during Fiscal Year 1986.

World Vision Relief Organization, as one element within this partnership, works directly with the U.S. government in areas such as food assistance through the P.L. 480 and Section 416 programs, grants for emergency relief assistance throughout sub-Sahel Africa, matching funds for developmental programs in Africa and Asia, as well as the Child Survival program.

Our largest Child Survival program to date is the Mashonaland East project in Zimbabwe. This project has been made possible through a Child Survial Fund grant provided in partnership with USAID. This grant was awarded in June of 1985, and by the conclusion of the project's three-year duration, an estimated 75,000 people will have benefited. World Vision has been careful to work through the relatively developed Zimbabwean health infrastructure in the implementation of this program. State registered nurses will administer vaccines. Existing Ministry of Health supplies will be utilized, including vaccines and growth monitoring cards. The cold chain methods used by local village health workers will not be altered, but only expanded. The project will work through and make the fullest use of existing community groups and leaders. Through this program World Vision hopes to expedite and to facilitate current capabilities in health care, with the final objective being the creation of a self-sustaining health program. Our overall experience with this program to date has been very positive. However, the challenge continues to lie in the choice as to which of so many needy areas will be selected to receive life-saving interventions. The Zimbabwe Child Survival Project is critical not only to those it serves, but also as a prototype in World Vision's efforts to implement our commitment to child survival.

World Vision is strongly committed to participation in the worldwide movement to immunize all children by 1991, and as a response to this commitment has been actively pursuing the development of a new and expanded organizational health strategy. This strategy has recently included the request to USAID for funding of three additional Child Survival Projects - in Kenya, Sudan and Senegal - which would serve a total population of approximately 320,000 people. In addition, the 400,000 children in World Vision's childcare project communities will be immunized by local health authorities in the next three years. World Vision is also organizing large immunization campaigns with special private funding from individual donors in the United States and Canada.

World Vision has also adjusted our internal structure to better facilitate and coordinate our child survival and immunization programs. Dr. Rufi Macagba, Senior Health Care Consultant at our International Office, has the responsibility of coordinating the expansion of World Vision's Child Survival and immunization programs. Ann Biro, WVRO's Primary Health Care Specialist, will coordinate the development of proposals to USAID for Child Survival and immunization programs. In addition, two field-based primary health care facilitators are being placed in each of our three regional offices. Our long-term plan is to further increase our management capacity with appointments of additional facilitators in each of our country field offices.

Our strategy is based on a commitment to supporting and implementing primary health care and child survival programs at the community level, and includes the commitment to immunization and the GOBI (Growth Charts, Oral Rehydration Therapy, Breast Feeding and Immunization) approach to child survival as an entry point into primary health care and holistic development. World Vision sees a criti-

cal relationship between relief programs and child immunization in providing a threshold to broader developmental impacts. Starting with the release of health problems, an organization can build upon community trust and a trained volunteer network to progress into meeting other basic needs for self-reliance within the community.

However, none of these goals can be met without continued and increased cooperation with sister agencies, UNICEF and the host country Ministry of Health. Moreover, they will not be accomplished without a continued commitment on the part of Congress and USAID to partner with the contributions of individual citizens to Private Voluntary Organizations. World Vision highly commends Congress and USAID for the increased availability of funding for Child Survival programs, and wholeheartedly supports the increased funding for child immunization currently being considered in H.R. 3894, the Universal Child Immunization Act. Particularly in this critical time of budget considerations under the Gramm-Rudman legislation, the commitment to Child Survival and immunization funding must be maintained. While we realize the considered need for difficult budget decisions, we must hope for continued Child Survival and immunization funding in the face of even greater needs and more limited resources in the developing world.

In summary, Mr, Chairman, World Vision supports the current and future Child Survival Initiatives of Congress, as well as the proposed Universal Child Immunization Act. World Vision is implementing successful health and Child Survival programs in nearly 50 countries, both through private funding and USAID matching contributions. These programs are benefitting nearly 1.4 million individual lives. We are committed to continue these programs and are prepared to expand them, if the Congress and the American public continue to support the expression of legitimate concerns in such tangible ways.

While a number of my colleagues in sister agencies could have shared their own experiences and thoughts with you today, I believe it is safe to say that I speak on behalf of all PVOs in emphasizing that we are prepared to participate in even greater ways, if funds continue to be made available. The tradegy is that the cost to us now is only a few dollars per child to save the estimated four million children who die each year from six immunizable diseases, and the additional five million who are permanently and needlessly disabled. We have a window of opportunity before us, with a growing public support, international commitment and political will behind us. To do less than all that we now can is to forsake the hope of current and future generations.

Additional Comments for the Record

Closing Remarks of Dean Hirsh, World Vision Relief Organization, and Comments and Recommendations from the InterAction Development Assistance Committee's Task Force on Child Survival and Development

In January 1986, World Vision Relief Organization and fifteen other InterAction members engaged in the delivery of primary health care services at the grassroots level joined together--under the mandate of the Development Assistance Committee of InterAction, a coalition of more than one hundred private and voluntary organizations working in international development, relief and reconstruction, migration and refugee assistance, public policy and public education on developing countries --to form a Task Force on Child Survival and Development.

The Task Force exists to enhance the effective delivery of child survival and development programs through the promotion of discussion of critical child survival and development issues, member coordination, and ongoing evaluation and analysis of current child survival initiatives.

InterAction's Task Force has been instrumental in articulating the concerns of those agencies involved in the delivery of child survival programs. In addition, InterAction has joined with the U.S. Committee for UNICEF to launch a major campaign for Child Survival to educate the American public on this critical issue.

On behalf of the Task Force, I would like to request the opportunity to submit recommendations in writing for consideration by the committee for strengthening the current child survival program--recommendations made in the spirit of our shared commitment to improve the lives of children and their families worldwide.

Comments and Recommendations From the InterAction Development Assistance Committee's Task Force on Child Survival and Development

We, the private voluntary organizations on the InterAction Development Assistance Committee's Task Force on Child Survival and Development, commend the Congress for their support and enthusiasm for programs which deal directly with the health needs of mothers and children. The Congress has been instrumental in translating concern for the welfare of the world's children into a major objective of US foreign assistance.

We also commend the Agency for International Development for its commitment to making child survival the focus of the AID health program and for the recent publication "Child Survival: Report to the Congress on the AID Program."

Saving children's lives, improving their prospects for the future, and enhancing the capability of parents to care for their children have historically been, and continue to be, key objectives of private voluntary organizations.

We embrace the intent of the Child Survival legislation, section 104(c)(2) of the Foreign Assistance Act of 1961, as amended, which reads:

> "In carrying out the purpose of this subsection, the President shall promote, encourage, and undertake activities designed to deal directly with the special needs of children and mothers. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat dierrhoeal disease, and education programs aimed at improving nutrition and sanitation and at promoting child spacing...."

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We are concerned, however, that the administration of the current child survival program limits the potential for fully meeting the original intent of the Congress. We believe that the following comments and recommendations will enhance the potential for meeting the goals of the legislation.

The current legislation calls for expenditure of Child Survival Funds to emphasize the direct delivery of services to mothers and children. It is our concern that current interpretation has resulted in a disproportionate allocation of child survival resources for research and technical assistance, rather than for promoting the direct delivery of services.

In keeping with the spirit of the legislation, it is our concern that an over emphasis on a few selected interventions have encouraged project designs which may not adequately address the appropriate priority child survival needs. The promotion of selected emphasis interventions does not adequately allow the community to determine where its health priorities lie; mothers, who may be expected to have the greatest impact on children's health, are not able to play an essential role in the decision-making process.

Recognizing the importance of reaching those populations in greatest need, we are concerned that current administrative practices unneccessarily limit child survival activities to a select number of countries, a select number of interventions, and a select number of target groups, and thus restricts the global impact, specifically at the grassroots level, which many of our organizations would be able to have.

Enhancement of the capacity of parents and local communities to maintain and expand on efforts to combat early childhood diseases is vital to ensuring a sustainable and effective delivery system. This requires a commitment far beyond current program cycles, and is the shared responsibility of PVO, local community, and other major donors.

To ensure viable and appropriate project design and delivery, we believe that current administrative procedures need to be modified to provide increased time for project planning. In addition, to ensure that those in need be reached on a timely basis, it is imperative that information on the availability of all sources of child survival funds, at all levels, be communicated to the implementing agencies on a timely basis.

Child Survival is a vital component of long term development in societies of the developing world. However, it is a step in the overall process of long term, integrated development. We hope that the widespread enthusiasm for saving the lives of children will be complemented by increased support for all areas of development-- including agricultural production, rural development education and training, energy and the environment, and economic development-- as they are vital to achieving life, human dignity, and the promise of a future.

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